Senate Committee on Health and Welfare
Senate Committee on Finance
House Committee on Health Care

ACT 48 INTEGRATION REPORT: The Exchange

Submitted by the Agency of Administration

With assistance from:

Agency of Human Services: Department of Vermont Health Access, Children and Families, and Health
Department of Banking, Insurance, Securities, and Health Care Administration

January 17, 2012

Executive Summary

The Patient Protection and Affordable Care Act, or Affordable Care Act (ACA), makes significant changes to Vermont's current health care programs and to the private insurance market. In addition, the ACA requires each state to develop a Health Benefits Exchange ("Exchange") as the marketplace for individuals and small businesses to shop for and enroll in health care plans. The Exchange must be up and running in time for Vermonters to enroll in health plans on January 1, 2014.

Act 48 creates the framework for Green Mountain Care, Vermont's universal and unified health system, to be implemented in 2017 or earlier if the federal government allows. This report presents options and recommendations for transitioning Vermont's current public and private health care system to that required by the ACA in 2014, and then to Green Mountain Care at the earliest possible time. Vermont's goal is to comply with the ACA and use the Exchange as the platform on which to build its universal health care system.

This report contains the following:

- Description of Vermont's publicly funded health care programs today
- Changes to those programs under the ACA
- Options for transitioning current programs to the ACA environment in 2014, including
    - Federal tax credits and cost-sharing subsidies for Exchange health plans
    - Potential for state subsidies in addition to the federal subsidies
    - Options for a Basic Health Program
- Description of Vermont's private insurance market today
- Changes to the market under the ACA, including
    - Impact on associations
    - Definition of "small employer"
    - Effect on insurance market outside the Exchange
    - Impact on specific groups, such as education employees, municipal employees, the self-employed, self-insured employers, large groups, and Medicare
- Opportunities for administrative simplification
- The ACA Essential Benefits Package and its effect on state insurance mandates
- Exchange plan design for individuals and small employers
- Exchange Qualified Health Plan designs
- Supplemental insurance coverage
- Individual mandate

I. Statutory Charge

No. 48 of the acts of 2011 (Act 48) creates the Vermont Health Benefit Exchange (the "Exchange") within the Department of Vermont Health Access ("DVHA").The Exchange is required by the federal Affordable Care Act to provide individuals and small businesses with qualified health benefit plans.

Section 8: Integration Plan of Act 48 calls for a report to inform the development of the Exchange. The following are components of that report:

1. A study on how to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with the Exchange, including information on whether it is advisable to establish a basic health program (BHP) for individuals with incomes above 138 percent of the federal poverty level (FPL) and at or below 200 percent of FPL to ensure that the health coverage is comprehensive and affordable for this population.

2. A study on the statutory changes necessary to integrate the private insurance markets with the Exchange, including whether to impose a moratorium on the issuance of new association policies prior to 2014, as well as whether to continue exemptions for associations pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Exchange and if so, what criteria to use.

   An examination of the advantages and disadvantages for the state, for the Exchange, for employers, and for employees, of defining a small employer, for purposes of the Exchange for the period from January 1, 2014 through December 31, 2015, as an employer with up to 50 employees or as an employer with up to 100 employees. This study requires an analysis of the impacts of the definition on teachers, municipal employees, and associations. For purposes of this analysis, Act 48 defines "employer" as all for-profit entities, nonprofit entities, public entities, and individuals who are self-employed. However, under the ACA, a self-employed individual may not purchase insurance in the small group, only in the individual market.

3. A study of the advantages and disadvantages for the state, for the Exchange, for employers, for employees, and for individuals of allowing qualified health benefit plans to be sold to individuals and small groups both inside and outside the Exchange.

4. A report on the advantages and disadvantages for the state, for the Exchange, for employers, for employees, and for individuals of allowing nonqualified health benefit plans that comply with the provisions of the Affordable Care Act to be sold to individuals and small groups outside the Exchange.

5. In consultation with the Green Mountain Care board, the Secretary of the Administration shall design a common benefit package for the Exchange. When

creating the common benefit package, the secretary shall compare the essential benefits package defined under federal regulations implementing the Affordable Care Act with Vermont's insurance mandates, consider the affordability of cost-sharing both with and without the cost-sharing subsidy provided under federal regulations implementing the Affordable Care Act, and determine the feasibility and appropriate design of cost-sharing amounts for evidence-based health services with proven effectiveness.

6. A report on the impact of the availability of supplemental insurance plans on offerings in the small and individual group markets.

7. A review of the requirements for maintaining minimum essential coverage under Section 1501 of the Affordable Care Act, including the enforcement mechanisms provided in that act and a recommendation on any additional enforcement mechanisms necessary to ensure that most, if not all Vermonters will obtain sufficient health benefit coverage.

II: Health Benefit Coverage in 2014

Public Health Care Programs in Vermont - Today

"Green Mountain Care" is the umbrella name for a suite of health care programs available to low-income Vermonters. Below is a description of the individual programs under Green Mountain Care.

Traditional Medicaid

Medicaid provides coverage for children, young adults under age 21, parents, pregnant women, caretaker relatives, people who are blind or disabled, and people age 65 or older. To be eligible for Medicaid, and individual must have income below the "Protected Income Level," or "PIL," and must not have assets above a specified level, depending on the composition of the family unit. The PIL ($958 per month for a family of two and $1300 for a family of four) is approximately 100% of the Federal Poverty Level (FPL). Medicaid beneficiaries receive a comprehensive benefit package, with only minimal cost-sharing requirements, and no premiums.

Medicaid Expansions Operated under Vermont's Global Commitment to Health 1115 Demonstration Waiver

The Vermont Health Access Plan (VHAP)

VHAP is a program available to adults age 18 and older who do not meet the eligibility requirements for Medicaid, and who have income that is under 150% FPL ($1397 per month for one person and $1892 for two people) for adults with no children, or 185% FPL ($2333 per month for a family of two and $3554 for a family of four) for parents who have minor children in the home. There is no assets test for VHAP, but eligible

applicants must have been uninsured for 12 months or more, with exceptions for people who recently lost their insurance because of a life change such as a divorce or loss of a job. VHAP provides a comprehensive package of benefits with very low cost-sharing; however, beneficiaries with income greater than 50% FPL ($466 per month for one person and $631 for two people) must pay a monthly premium that is indexed to their income level.

Dr. Dynasaur

Dr. Dynasaur provides coverage for children under age 18 whose families have income under 300% FPL ($3783 per month for a two-person family and $5763 for a family of four), and for pregnant women with income under 200% FPL ($2522 per month for one pregnant woman, who is allowed the income maximum for a two-person family). There is no assets test, and beneficiaries may have private insurance coverage and still qualify for Dr. Dynasaur. Pregnant women and families with children on Dr. Dynasaur must pay monthly premiums that are indexed to income. There is no cost sharing.

Catamount Health Premium Assistance (CHAP)

Catamount Health is a private health insurance plan, offered in cooperation with the state of Vermont, by Blue Cross Blue Shield of Vermont and MVP Health Care. People who have been uninsured for 12 or more months, with some exceptions for loss of insurance due to a life change, and who have income less than 300% FPL ($3783 per month for a family of two and $5763 for a family of four) may qualify for premium assistance based on a sliding scale. There is no assets test for eligibility for premium assistance.

Employer-Sponsored Insurance (ESI) Premium Assistance

People who otherwise meet the eligibility criteria for VHAP or CHAP may receive premium assistance to enroll in their ESI plan if it is more cost-effective for the state than enrolling them in either VHAP or CHAP. Beneficiaries enrolled in ESI premium assistance pay a monthly premium equivalent to that paid by beneficiaries in VHAP or CHAP. Beneficiaries otherwise eligible for VHAP but enrolled in their ESI plan receive wrap-around coverage for cost-sharing required by their ESI plan. Beneficiaries otherwise eligible for CHAP but enrolled in their ESI plan receive wrap-around coverage for the prevention and maintenance of certain chronic conditions.

Prescription Assistance

Vermont has several Prescription Assistance programs to help uninsured Vermonters and those enrolled in Medicare pay for prescription medicines based on income, disability status and age.

These programs include:

- **VPharm** assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. The program serves people age 65 and older, as well as people of all ages with disabilities, and includes an affordable monthly premium.

- **VHAP-Pharmacy** helps Vermonters age 65 and older and people with disabilities who are not enrolled in Medicare pay for eye exams and prescription medicines for short-term and long-term medical problems. There is an affordable monthly premium.
- **VScript** helps Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for prescription medicines for long-term medical problems. There is also a monthly premium based on income.
- **Healthy Vermonters** provides a discount on short-term and long-term prescription medicines. There are no monthly premiums and eligibility is based on family income.

Long-Term Care Medicaid (Operated in Vermont with benefit enhancements under the Choices for Care 1115 Demonstration Waiver)

Vermont's Long-Term Care Medicaid Program helps eligible Vermonters pay for long-term care services in the setting of their choice. To be eligible, people must have income and assets below the Medicaid limits.

Beneficiaries may choose from these settings:

- The beneficiary's own home or the home of another person;
- An approved residential care home or assisted-living facility; or
- An approved nursing home.

Medicare Savings Programs

There are several programs that assist individuals with income under specified FPL limits (ranging from 100%, or $931 per month for one person, to 200%, or $1862 per month for one person, depending on the program) in paying their Medicare Part A and/or Part B premiums.

Table 1 below is a graphic representation of the programs available today, as described above:

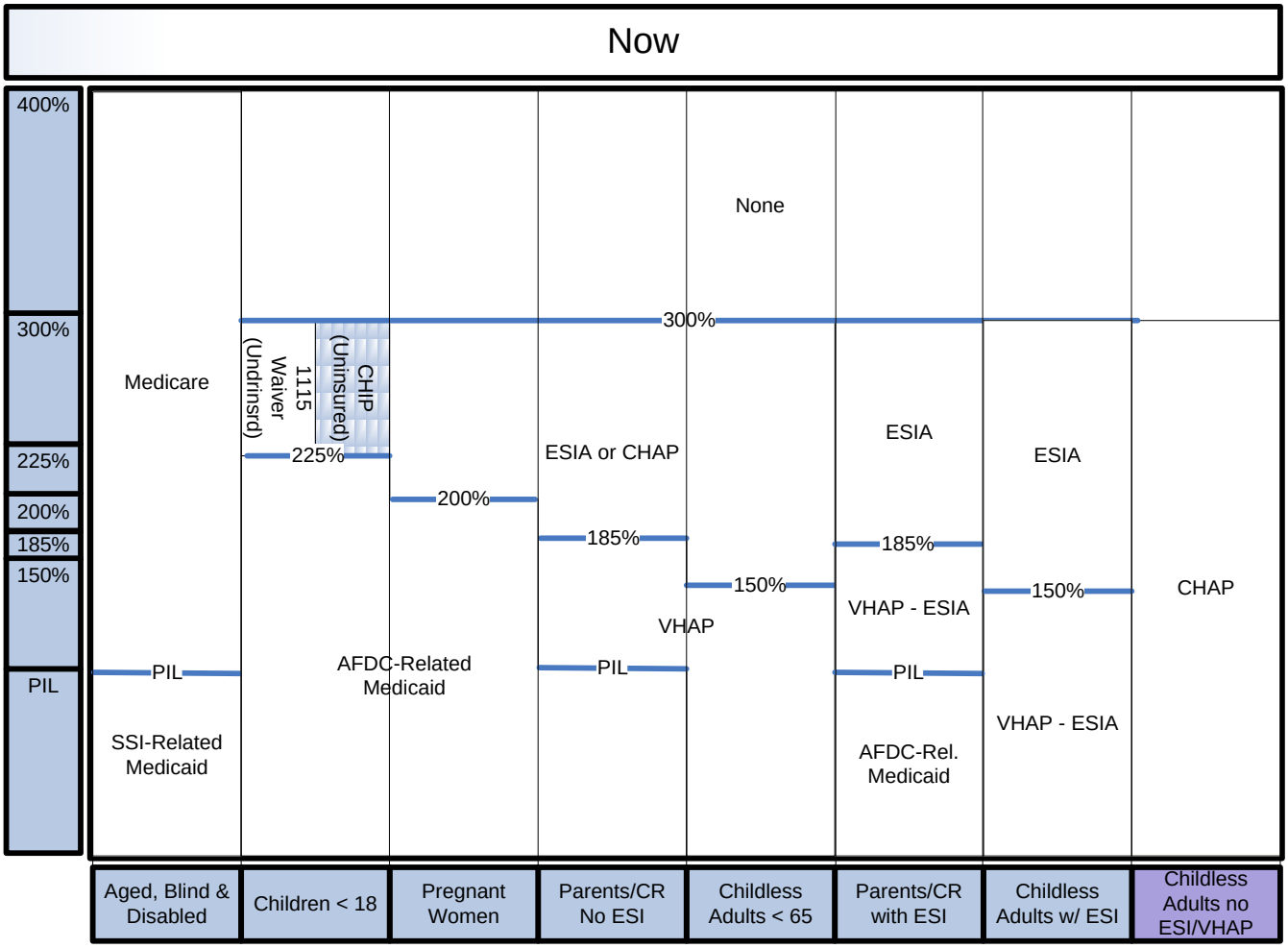


Table 1.

ACA Changes in 2014

Eligibility Changes

The Affordable Care Act (ACA) extends and attempts to simplify traditional Medicaid eligibility. Starting in calendar year 2014, it consolidates some of the complex categorical groupings. It also extends traditional Medicaid eligibility to all individuals under age 65 with income at or below 138% FPL ($1285 per month for one person or $1740 per month for two people) and who meet certain non-financial eligibility criteria, such as citizenship or satisfactory immigration status. All newly-eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

Due to existing state-established income eligibility standards, in Vermont and other states, children and pregnant women will be eligible at income levels higher than 138% FPL. In addition, states will have a new option to expand eligibility beyond the new simplified Federal minimums.

According to the language in the ACA, Vermont's current programs would be affected or not affected as follows in 2014:

- Programs for children (Dr. Dynasaur) would remain unchanged until 2019 due to a Maintenance of Eligibility requirement in the ACA
- Adults in VHAP with incomes at or below 138% FPL would transition to traditional Medicaid
- Adults in VHAP with incomes above 138% FPL would be eligible for tax credits and cost-sharing subsidies for private plans offered through the Exchange, but may be served through a Basic Health Program (state policy choice)
- Adults in VHAP-ESIA with income at or below 138% FPL would transition to traditional Medicaid and may or may not be eligible for premium assistance if they wanted to remain enrolled in their ESIA plan (state policy choice)
- Adults in VHAP-ESIA with income above 138% FPL may or may not be eligible for premium assistance; individuals employed by small employers may be able to buy through the Exchange (state policy choice)
- Adults in Catamount Health premium assistance (CHAP) with income under 138% FPL would transition to traditional Medicaid
- Adults in CHAP with income above 138% FPL would be eligible for tax credits and cost-sharing subsidies for private plans offered through the Exchange, as long as they do not have access to an ESI plan.

In general, people enrolled in programs other than those described above would not experience any changes in 2014. This includes individuals on Medicare or who are eligible for both Medicare and Medicaid ("dual eligible").

Adults with income above 138% FPL, and who have access to an employer-based plan that meets certain requirements, are eligible to purchase insurance through the Exchange only if their employer purchases insurance through the Exchange. These individuals, however, are not eligible for federal tax credits or cost-sharing subsidies. Only small businesses may offer their employees insurance through the Exchange in 2014. Large businesses may offer insurance through the Exchange in 2017; however, Vermont expects to request a waiver from the Exchange in order to implement a single, unified Green Mountain Care program.

Vermont could choose to implement a Basic Health Program for people with income from 138% to 200% FPL. There is a more detailed description of the Basic Health Program in a subsequent section of this report.

Table 2 below is a graphic representation of the program categories in 2014 if Vermont were to implement the changes as defined in the ACA:

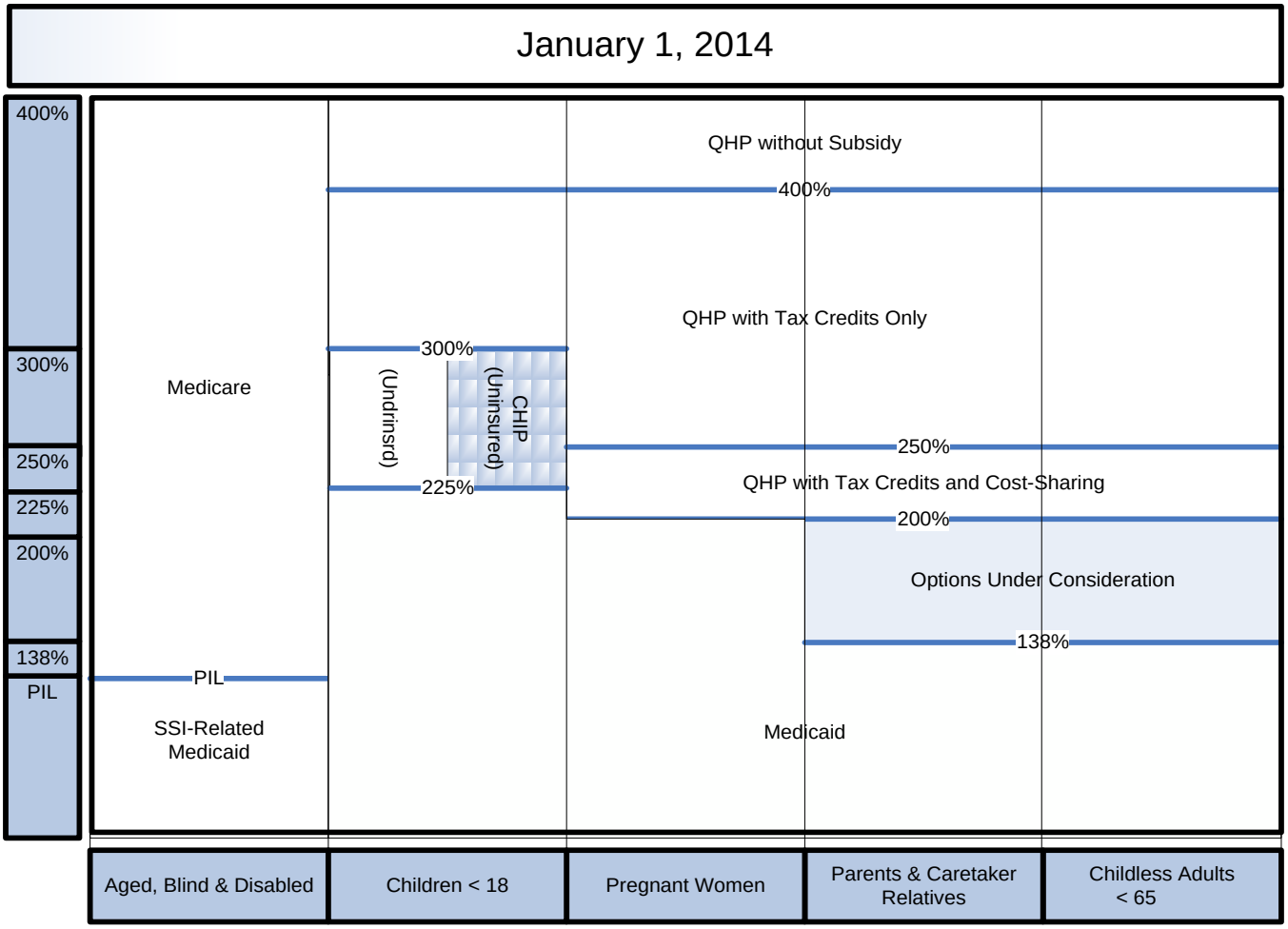


Table 2.

New Methodologies for Financial Eligibility Determination

Beginning on January 1, 2014, eligibility for Medicaid for most individuals, as well as for the Children's Health Insurance Program (CHIP), will be determined using methodologies that are based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code of 1986 (IRC). The ACA also eliminates the current assets test for individuals whose income eligibility is based on MAGI. Current income and resource standards will remain unchanged for many individuals, including those who are disabled or age 65 or older.

Currently states are permitted to expand Medicaid eligibility for certain groups by employing an array of income disregards. For example, parents with children are permitted to disregard a portion of their earned income and all of their child care expenses up to a maximum allowable deduction when income eligibility for Medicaid is determined.

Effective January 1, 2014—except for an across-the-board, five percent income

disregard—states will no longer be able to employ this strategy in determining eligibility for individuals whose eligibility is based on MAGI.

Expansion State Financing

The ACA provides states with enhanced federal funding to support its Medicaid expansion. In states where the newly eligible would not have otherwise qualified for health care benefits, the federal government will initially cover the entire cost of coverage. The federal share will then gradually decline to 90 percent in 2020. "Expansion states"—states like Vermont that already extend health care benefits to at least some of those who will become newly eligible for Medicaid—will receive enhanced federal funding for many of those who will transition from an expansion program to Medicaid. The federal share will begin at about 73 percent and then gradually ramp up to 90 percent in 2019.

Depending on existing eligibility standards, in some states, all of the newly eligible will be people who would not have otherwise qualified for health benefits. In others, there will be a blend of "true" newly eligibles and those who are newly eligible for Medicaid, but who would have otherwise qualified for an expansion program. Due to the generosity of their existing expansion programs, however, in Vermont and Massachusetts, virtually all of the people who become newly eligible for Medicaid will have been eligible for an expansion health benefit. As these two states will not initially receive 100 percent federal funding for any of their newly eligibles, the ACA extends to Vermont a general 2.2% increase in the rate that the federal government would otherwise have paid to support the entire Medicaid populations (Massachusetts will also receive a federal funding increase, though not as high as Vermont's). This enhanced rate is available for calendar years 2014 and 2015.

Twenty-First Century Consumer Experience

A basic tenet of the ACA is that consumers should have a streamlined, first-class, 21st-century customer experience when they enter Exchanges. In 2014, the Act contemplates that consumers will have the same enrollment experience whether they enter through the Exchange, Medicaid, or CHIP. Federal guidance calls for a highly responsive level of consumer service, modeled on retail, banking, airlines, and other industries.

Among other things, the federal government requires states to develop a transparent, easy-to-use, online process for consumers to make choices, apply, recertify, modify, and manage benefits in the Exchange. Guidance articulates a consumer-mediated approach in which consumers own their data and make decisions about how, when, and with whom it is shared. Consumer usability is also spelled out in the federal guidance, and Exchange systems must support a range of languages and user capabilities.

In addition to web-based applications, the proposed regulations require states to establish procedures to permit application by telephone, mail, or in-person.

According to federal guidance, consumers can expect real-time transactions, electronic verification of eligibility from federal and state databases, and third-party assistance in

enrolling in and maintaining coverage. Consumers will enter a minimal amount of personal information, and Exchange systems must provide real-time notification of eligibility and enrollment and seamless integration among all qualified health insurance options. Systems also need to facilitate timely resolution of discrepancies for people who cannot be handled in real-time.

Administrative Requirements

The proposed federal regulations contain a number of provisions aimed at the administration of the health benefits eligibility determination process. In addition to ensuring a consumer-friendly enrollment experience, these provisions are intended to promote administratively efficient, streamlined, and coordinated eligibility business processes.

Under the proposed paradigm, individuals will be evaluated and enrolled in the appropriate program regardless of where the application originates. An individual who applies for Medicaid and is found to be ineligible will be immediately assessed for eligibility for advance payment of the health insurance premium tax credit and coverage through the Exchange.

Vermont is pursuing a fully integrated, automated eligibility system that will determine eligibility for all of the state's health care programs. Further, it will employ common income methodologies and aligned rules to evaluate eligibility for most individuals for Medicaid, CHIP, and the Exchange.

Coverage Options in 2014

As discussed above, the ACA extends and expands health care benefits to a large segment of Americans. While these changes will largely advantage low-income Vermonters, it is possible that, given Vermont's current, relatively generous health benefits offerings, there will be pockets of individuals with incomes over the new Medicaid maximum who could incur increased health care costs under the ACA's national paradigm. In light of this reality, this report evaluates the following three coverage options for those with incomes between 138% and 200% FPL:[1]

- **Option 1: Exchange premium and cost-sharing subsidies.** Eligible individuals would enroll in a Qualified Health Plan (QHP) through the Exchange and receive federal premium tax credits and cost-sharing reductions, as provided in the ACA.

[1] The Administration recognizes that there may be people with incomes between 200% and 300% FPL who could also experience negative consequences under the ACA. However, this analysis focuses on those in the 138%-to-200% income range, as this group encompasses those who are currently eligible for VHAP. 200% FPL was selected as the income maximum (rather than 150% or 185% FPL—the current VHAP income maximums) as this aligns with the federally-specified income maximum for the Basic Health Program—one of the three coverage options for this group. Vermont may want to consider options for those with incomes between 200% and 300% FPL as well.

- **Option 2: Exchange premium and cost-sharing subsidies, supplemented with additional state subsidies.** Eligible individuals would enroll in QHPs with federal premium and cost-sharing subsidies. The state would augment the federal benefits with additional subsidies, designed to approximate out-of-pocket parity with current Vermont health benefit programs.
- **Option 3: Basic Health Program.** Eligible individuals would enroll in a Basic Health Program, which would provide Medicaid look-alike coverage with premiums and cost-sharing requirements at current VHAP levels.

Medicaid Expansion

Beginning in 2014 states will have the option to extend coverage at higher income levels through adoption of a new optional Medicaid group. States that choose this option will have the discretion to set the maximum income limit for this new group. Theoretically, then, Vermont could extend the 138% FPL income limit for Medicaid to a higher limit of its choosing. However, if Vermont decided to increase the income limit for Medicaid, it would have to pay 40+% of the cost of the additional people covered, whereas these same people would be eligible for 100% federally-funded tax credits and cost-sharing subsidies through the Exchange. Increasing the Medicaid income limit would therefore be a more expensive option than creating a Basic Health Program or allowing people to buy private insurance plans through the Exchange. As such, the Administration is not aware of any states that are considering this option.

The following section provides detailed summaries of each of the three options named above and a comparison of their relative strengths and weaknesses.

Option 1: Premium Tax Credits and Cost-Sharing Subsidies under ACA

The ACA creates tax credits and cost-sharing subsidies for people with income below 400% ($5044 per month for a family of two and $7684 for a family of four) who buy private insurance through the Exchange. The amount of the tax credits and cost-sharing subsidies is based on household income reported on tax returns. The following table (Table 3) shows what percentage of income individuals at various income levels would be expected to pay for insurance premiums in the Exchange based on current FPL levels:

FPL	ACA required premium as % of income	ACA required premium in dollars	Current premium levels in VHAP & CHAP[1]
0- 50%	0.0%	$0	$0
50 - 75%	0.0%	$0	$7
75 - 100%	0.0%	$0	$25
100 - 138%	2.0%	$18 - $25	$33
138 - 150%	3-4%	$37 - $55	$33
150 - 200%	4-6.3%	$55 - $116	$49
200 - 225%	6.3%	$116 - $131	$124
225 - 250%	6.3%	$131 - $145	$152

250 - 275%	8.1%	$187 - $205	$180
275 - 300%	8.1%	$205 - $224	$208
300 - 350%	9.5%	$263 - $306	
350 - 400%	9.5%	$306 - $350	

[1]People enrolled in Catamount Health with premium assistance (CHAP) with income under 200% FPL pay a $60 monthly premium.

Table 3.

So the ACA expects an individual with an income of 150% FPL ($1397 per month for an individual) to pay 4% of income, or $55 per month toward the insurance premium. The tax credit amount would be the actual premium cost minus $55.

In addition to tax credits, individuals and families with income below 250% FPL ($3153 per month for a two-person family and $4803 for a four-person family) are entitled to cost-sharing subsidies. The cost-sharing subsidies are intended to reduce out-of-pocket spending by bringing the actuarial value (the percent of an average individual's medical expenses that a plan pays) of a silver plan up to the actuarial value listed in the table below (Table 4).

2011 FPL range	Actuarial value
0- 50%	97%
50 - 75%	97%
75 - 100%	97%
100 - 138%	97%
138 - 150%	94%
150 - 185%	87%
185 - 200%	87%
200 - 225%	73%
225 - 250%	73%

Table 4.

So an individual who purchases a silver plan (70% actuarial value), and whose income is 140% FPL, would receive a cost-sharing subsidy equal to 94% minus 70%. The cost-sharing subsidy would be paid by the federal government to the issuer of the plan the individual chooses.

The ACA requires the out-of-pocket maximum (which is the highest amount that a plan enrollee must pay in cost-sharing, including deductible, co-pays, and co-insurance) to be no more than $5950 per year; however, for people under 400% FPL, the out-of-pocket maximum is reduced according to income levels. The following chart (Table 5) shows the out-of-pocket maximums under the ACA for individuals at various income levels.

Income level	Out-of-pocket reduction	Out-of-pocket max in $
100-200%	2/3 of maximum	$1983
200-300%	1/2 of maximum	$2975
300-400%	1/3 of maximum	$3967
400%+	Maximum	$5950

Table 5.

Table 6 below compares monthly premiums and the out-of-pocket maximums under the current VHAP and Catamount Health premium assistance program (CHAP) to anticipated premiums and out-of-pocket maximums under the ACA.

Monthly Impact on Out-of-Pocket Costs under ACA				
2011 FPL range	ACA required premium in dollars	Current premium levels in VHAP & CHAP	ACA out-of-pocket max	Current VHAP/CHAP out-of-pocket max
0- 50%	$0	$0	N/A[1]	N/A
50 - 75%	$0	$7	N/A	N/A
75 - 100%	$0	$25	N/A	N/A
100 - 138%	$18 - $25	$33	N/A	N/A
138 - 150%	$37 - $55	$33	$1983	N/A
150 - 185%	$55 - $116	$49	$1983	$1050[2]
185 - 200%	$116 - $131	$60	$1983	$1050
200 - 225%	$131 - $145	$124	$2975	$1050
225 - 250%	$187 - $205	$152	$2975	$1050
250 - 275%	$205 - $224	$180	$2975	$1050
275 - 300%	$263 - $306	$208	$2975	$1050

[1]People enrolled in VHAP have minimal cost-sharing: $1 and $2 pharmacy co-pays and a $25 co-pay for emergency room visits.

[2]Parents of minor children are eligible for VHAP if their income is < 185% FPL, so they would have VHAP-level cost-sharing only.

Table 6.

As can be seen in this chart, individuals who have medical expenses in one year that exceed the Catamount $1050 out-of-pocket maximum could pay more if enrolled in a plan on the Exchange; however, not all enrollees would have medical expenses that would reach this threshold. Furthermore, it is not yet clear how the cost-sharing subsidies would affect the out-of-pocket maximums set by the ACA. For example, people in the income range of 138-150% FPL are eligible for a cost-sharing subsidy that would increase the actuarial value of their silver plan from 70% to 94%, so it is not likely that they would have an out-of-pocket maximum as high as $1983. The federal government

has not yet released proposed regulations on how cost-sharing subsidies will actually work, so it is not possible at this time to make a definitive comparison.

The above analysis is based on the impact on individuals, or households of one person. Couples will most likely have less cost-sharing under ACA at all income levels, since in VHAP and CHAP, couples pay twice the premium paid by individuals with the same household income. Under ACA, there will be one premium per household based on household income. For instance a CHAP couple at the highest income level (275-300% FPL, or $3468 to $3783 per month) pays twice the individual premium of $208, or $416. Under ACA, that same couple would pay a premium of $262. An analysis of the impact of ACA on family coverage has not been completed, and would be complex due to the fact that parents and children may be eligible for coverage in different programs; this is true today and will also be true under the ACA.

Option 2: Potential for State Subsidies

The Administration has had discussions with stakeholders about the possibility of providing wrap-around benefits to consumers with incomes below 300% who would be enrolled in private plans in the Exchange to defray some or all of the higher premium and cost-sharing potentially required under the ACA.

DVHA currently provides wrap-around benefits to VHAP-eligible people who are enrolled in their employer-sponsored insurance (ESI) plans. The ESI plan is the primary payer, but VHAP pays for services not covered by the ESI plan plus cost-sharing that would otherwise result in out-of-pocket spending for the enrollee. Catamount-ESIA enrollees are eligible for partial wrap-around benefits that cover the prevention and maintenance of certain chronic conditions.

It would be feasible for the State to include a state subsidy as a component of its program under the ACA. Cost-sharing subsidies are potentially complex to administer for the state and without additional federal guidance we cannot evaluate the administrative mechanisms for building off the federal subsidies.

On the other hand, health care providers might prefer this type of program, because the individual will be enrolled in an insurance product. This results in the providers being paid at commercial rates, not Medicaid rates.

In addition, enrolling more individuals into the Exchange is beneficial to Exchange sustainability and ensures that the state-of-the-art features of an Exchange are utilized by more people.

Option 3: Basic Health Program

The ACA offers states the option to implement a Basic Health Program (BHP) to adults with incomes between 138% and 200% FPL and legally resident immigrants with incomes below 138% FPL whose immigration status disqualifies them from federally-

matched Medicaid. The federal government will reimburse states 95% of what they would have spent on premium tax credits and cost-sharing reductions had such eligible individuals been enrolled in qualified health plans through the Exchange.

The BHP must include at least the essential benefits under ACA, and consumers may not be charged more in premiums than what they would have paid in the Exchange. In addition, cost sharing must be no greater than a platinum plan (90% actuarial value) for individuals with incomes less than 150% FPL or a gold plan (80% actuarial value) for individuals with incomes between 150 and 200% FPL.

States that elect to implement a BHP must contract with a "managed care system" or a "system that offer(s) as many of the attributes of managed care as are feasible in its local health care market." In addition, plans must report on selected performance measures and must also maintain medical loss ratios of 85 percent or higher. It is not clear in the ACA whether Vermont could run its own managed care arrangement using a fee-for-service (FFS) payment system with primary care case managers. A BHP must also include case coordination and case management, incentives for preventive services, maximization of patient involvement in health care decision-making, and incentives for appropriate utilization.

If states choose to implement a BHP, eligible individuals cannot receive tax credits through the Exchange. The federal government will make a single payment to the state at the start of the fiscal year based on best available estimates and will make corrections (if the amount was too high or low) in the next year's payment (this process is called "reconciliation").

Policy Considerations for the Three Options

In order to choose the best coverage option to pursue for individuals with incomes between 138% and 200% FPL, it is important to understand the implications regarding how they will impact the enrollee, the impact on the overall health care system and providers, the effect on the public resources available to support the options, and how they align with the state's goal to move to a single payer system in 2017. The following narrative provides a description of these issues.

Enrollee Experience

Areas of consideration should include the enrollees' experience with transitions among programs, the covered benefits and costs of the coverage options, impact on access to care, and the processes related to consumer protections.

Transitions

Individuals will need to go through a new enrollment process regardless of the option available to them. As previously noted, individuals are currently spread among multiple programs, depending on their income level. For the most part, childless adults with

incomes up to 150% and parents of minor children with incomes up to 185% are currently enrolled in VHAP, a state-run coverage program. Others are enrolled in a private insurance option and receive state subsidies to lower their premiums (i.e., CHAP and ESIA as described in Section 3(I)(A) of this report). Regardless of the new coverage option chosen, some individuals will be required to change, either from a publicly-managed plan to a private insurance plan or from private insurance to a publicly-managed plan.

In addition, individuals with relatively low incomes have more frequent fluctuations in their incomes related to their employment status or other life situations; these fluctuations cause changes in their eligibility for insurance coverage options. Frequently called "churn," it is beneficial, for the both the individual and the State, to minimize this phenomenon to avoid confusion and lack of continuity of care for individuals and administrative complexity for the State. If the State were allowed by the federal government to administer the BHP and keep benefits the same or substantially similar to Medicaid benefits, people with fluctuating income below 200% FPL would experience fewer transitions between Medicaid and private insurance. The state subsidy would also assist with reducing churn, because there would be one transition from Medicaid to the Exchange at 133% FPL.

Covered Benefits

The covered services would be the same for the two options that involve the Exchange, while the services covered in a Basic Health Program could be those within the existing Medicaid or VHAP program. The Exchange services covered would be fewer than those covered under Medicaid; however, VHAP coverage is very similar to the coverage provided by Catamount Health. As discussed later in this report, a state is able to choose the coverage offered in the Exchange and base it on an existing health plan offered in that state, so it is likely that the covered services would be the same as today.

Another area for consideration is the impact on families. Children in households with incomes up to 300% FPL will continue to have coverage through Dr. Dynasaur. If adults access a plan through the Exchange, the family would have two types of health benefit plans similar to what happens today when children in a family are enrolled in Dr. Dynasaur and the adults are enrolled in Catamount Health. For families under 200% FPL, if the adults enrolled in a Basic Health Program, the family members would all be on a state-managed program with very similar covered services. Families with incomes over 200% FPL would be in the same position as today with the children on Dr. Dynasaur and the adults in an insurance product.

Costs

As discussed in the section describing Option 1 above, the cost-sharing premiums paid by individuals within the Exchange will vary based on income level, and may be more or less than they currently pay under VHAP or Catamount. The State can choose to provide state subsidies in addition to the federal subsidies to minimize the impact of this cost

(Option 2). Under the state-run Basic Health Program option, the premiums could remain similar to the premiums that these individuals currently pay.

The table in the Option 1 section above also shows a comparison of the premiums and out-of-pocket maximums for individuals enrolled in the Exchange vs. current out-of-pocket costs. Some individuals may have much more exposure for out-of-pocket costs in Option 1 (Exchange only). In Option 2, the State would "wrap" these costs so that individuals would not have as much exposure. Under the Basic Health Program, out-of-pocket costs might be minimal, as they are today under the Medicaid program.

Access to subsidies may also present challenges. Since people enrolled in a BHP are not subject to the IRS reconciliation process at the end of the tax year, as they would be with premium tax credits in an private insurance product, they would be spared the hardship that would result if the IRS determines they were overpaid in tax credits and must therefore pay back a portion of what they were overpaid. However, ACA limits the repayment liability to $300 for people below 200%.

It should be noted that, although a BHP may offer greater financial protection for consumers, it transfers the liability for repayment to the State, with no limitations on liability. Under a BHP, the State would receive 95% of the projected premium tax credits and cost-sharing subsidies that would have been paid by the federal government if those same individuals had been enrolled in private insurance through the Exchange. However, at the end of the year, the federal government (IRS) will compute actual eligibility for tax credits and cost-sharing subsidies based on tax returns filed by individuals in the BHP. If the IRS finds that a state has been overpaid, the state must repay the amount it was overpaid. A recent article by the Institute for Health Policy Solutions warns of this risk, as follows: "One potentially critical but difficult-to-grasp dimension is the possibility of major differences in applicants' own projections of income when applying for a subsidized public-program-model BHP as opposed to a federal tax credit which is ultimately based on actual year-end income."[2]

Quality of Care / Access to Care

The plans offered through the Exchange will provide services through the network of providers enrolled under that specific plan. Insurance plan networks in Vermont are not tightly managed and often include an expansive list of providers. However, these networks may not be as robust as the provider network that serves Medicaid beneficiaries, as Medicaid enrolls any provider willing to be a part of the State's network, as long as the provider is licensed or certified and not under sanction by Medicare. On the other hand, the Medicaid network is influenced by the relatively low provider payment rates and not all providers are willing to take Medicaid patients (see discussion under section below on Provider Payment). It is difficult to assess access to care and which option it supports.

[2] "Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program (BHP) in California," Rick Curtis and Ed Neuschler, Institute for Health Policy Solutions, September 2, 2011

Consumer Protections

The rights of beneficiaries, and the grievance and appeals processes, within the Medicaid program are governed by very stringent federal criteria designed to protect beneficiaries and to ensure that the processes are transparent and relatively easy to navigate. Commercial plans do not follow the federal guidelines, however, state law provides for a grievance and appeal process for insurance plans.

Impact on Vermont Health Care System and Providers

Areas of consideration within this category should include the impact on enrollment in the private market, sustainability of the Exchange, and effect on provider payment.

Private Market Enrollment

Options 1 and 2 would increase enrollment in the private market, while the BHP under Option 3 would decrease this enrollment.

Exchange Sustainability

As Vermont moves to its single-payer system it would like to use the Exchange as a platform and encourage as many people as possible into the Exchange. If the State continues to operate an expanded Medicaid program through a BHP, fewer individuals would be purchasing via the Exchange. This could present challenges for the financial viability of the Exchange because of Vermont's small market size, although as Vermont moves towards a single-payer model, this issue will resolved. The estimated projection for participation in the Exchange (excluding small business, or SHOP, enrollment) beginning in 2014 is 31,025 people. If the State decided to establish a BHP, it is estimated that the enrollment in the Exchange would drop to 16,508.

In terms of the impact on premiums, it is currently unclear whether the people enrolled in VHAP between 138% and 200% FPL have better or worse insurance risk than those purchasing insurance through Catamount, those in the non-group market, and newly-eligible uninsured between 200 and 400% FPL. The actuarial analysis described later in this report included this group in the pool and this is more fully discussed later. It is unclear whether the federal government will allow the Basic Health Program risk pool to be merged with rest of the individual or small group markets. It is important to understand the differences in risk profiles if the federal government does not allow the pools to be merged, since these differences would impact the analyses and projections included above.

Provider Payment

It is likely that a BHP would pay providers at lower rates than would a private insurance plan; however, it would not necessarily have to pay providers at Medicaid rates. Some of the savings to the State could be used to increase provider rates to levels above the Medicaid rates. The ACA requires any savings realized from operating a BHP to be used only for the benefit of the BHP enrollees, which could limit the use of BHP savings to increase Medicaid provider rates as well (see additional discussion in the section on Fiscal Considerations below). The State is awaiting rules on the BHP, so it is possible that the rule may provider additional flexibility to states through an exception or waiver process.

Impact on Public Resources

Controlling the costs with the State's health care system is a major goal of Vermont's health care reform. As such, the impact of each of these three options on administrative costs and on the current support for public programs is important to understand.

Administrative Resources

Recent Vermont studies indicate that the administrative costs within commercial products are higher than the administrative costs for running the State's Medicaid programs.[3,4] As such, these costs will be higher in Options 1 and 2, as compared to Option 3. They also may be more costly in Option 2 as compared to either of the other two, depending on the complexity of administering the state subsidy. One of the goals of the Exchange, however, is to reduce administrative costs in the individual and small group markets.

Support of Public Resources

Vermont's Global Commitment to Health 1115 Medicaid Demonstration has enabled the State to fund creative alternatives to traditional Medicaid services that have helped improve quality of care and control costs. For example, the State has been able to fund services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation), and invest in programmatic innovations for Medicaid beneficiaries (e.g., the Vermont Blueprint for Health multi-payer advanced primary care practice program). In addition, provided that the State meets its contractual obligation to the populations covered under the Demonstration, matched federal revenues may also be used for the following purposes:

- Reduce the rate of uninsured and or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;

[3] Health Plan Administrative Cost Report , Department of Banking, Insurance and Health Care Administration, , December 2009.

[4] Administrative Cost Effectiveness of the Vermont Catamount Health Program, Final Report for the Vermont Health Care Reform Commission prepared by the University of New England's Center for Health Planning, Policy and Research, March 2, 2010.

- Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Through this mechanism, each year, the State has been able to use between $53.5 and $65 million dollars to pay for services or other needs under these four categories. As such, this mechanism has brought an average of $36 million in additional federal dollars into Vermont each waiver year. Examples include respite services for families with disabled children; substance abuse treatment services for uninsured and underinsured Vermonters; mental health peer support and education; tuition support for health professionals under short supply in Vermont, such as nurses, primary care physicians, nurse practitioners, dentists, nurse faculty, and dental hygienists; and support for development of standards and training for medical emergency care. All of these investments help improve the health care provided within Vermont and also help control costs.

If the federal government allows Vermont to operate the Basic Health Program as a component of the Global Commitment demonstration, the ability for Vermont to continue this amount of financial support for these types of services and programs will be preserved and possibly enhanced. On the other hand, if Vermont does not offer a state-run Basic Health Program, the available resources to support these programs may be reduced due to lower enrollment in the Medicaid demonstration.

Summary

The State has two good options to consider for moving from today's fragmented coverage model to a model in 2014, which will reduce churn and provide good health coverage options to low- and middle-income individuals.

There are still many questions about the Basic Health Program (BHP) that cannot be answered until the federal government releases BHP regulations and answers the State's question on whether DVHA, operating under a Medicaid Managed Care model, could administer the BHP rather than contracting with an insurer. The State would also need to be able to seek a waiver if it wanted to use BHP savings to increase provider rates for the Medicaid, as well as the BHP, populations. Because this would provide the State with more flexibility, it is worthwhile keeping this option on the table.

Additionally, the State could provide a state subsidy to individuals through the Exchange, which is also attractive in many ways. This could ensure that individuals have affordable premiums and cost-sharing, increase provider rates, and enroll individuals into the Exchange.

Fiscal Considerations for Three Options

Vermont currently offers coverage through the VHAP and Catamount programs for uninsured adults with incomes between 138 and 200% of the Federal Poverty Level. Under the Global Commitment to Health Demonstration, Federal Financial Participation (FFP) is available to support these programs. Total public funding for individuals in this income range who are enrolled in VHAP or Catamount is approximately $45 million ($20 million in state funds and $25 million in federal funds).

Beginning in 2014, the ACA provides federal subsidies to make affordable coverage available to uninsured adults in this income group. The ACA does not contemplate a state contribution.

Vermont may choose to explore options to build on the successes of its current programs in making affordable coverage available by either:

- Subsidizing individual cost-sharing obligations for products offered under the Exchange
- Developing a Basic Health Program to be operated within the State public managed care model

The Centers for Medicare and Medicaid Services (CMS) is in the process of developing regulations and issuing guidance with regard to numerous policies under the Exchange. Therefore, development of detailed fiscal projections is challenging and subject to substantial modification once additional federal guidance becomes available.

The chart below provides a rough summary of the average, per-person costs for the current programs and options for consideration.

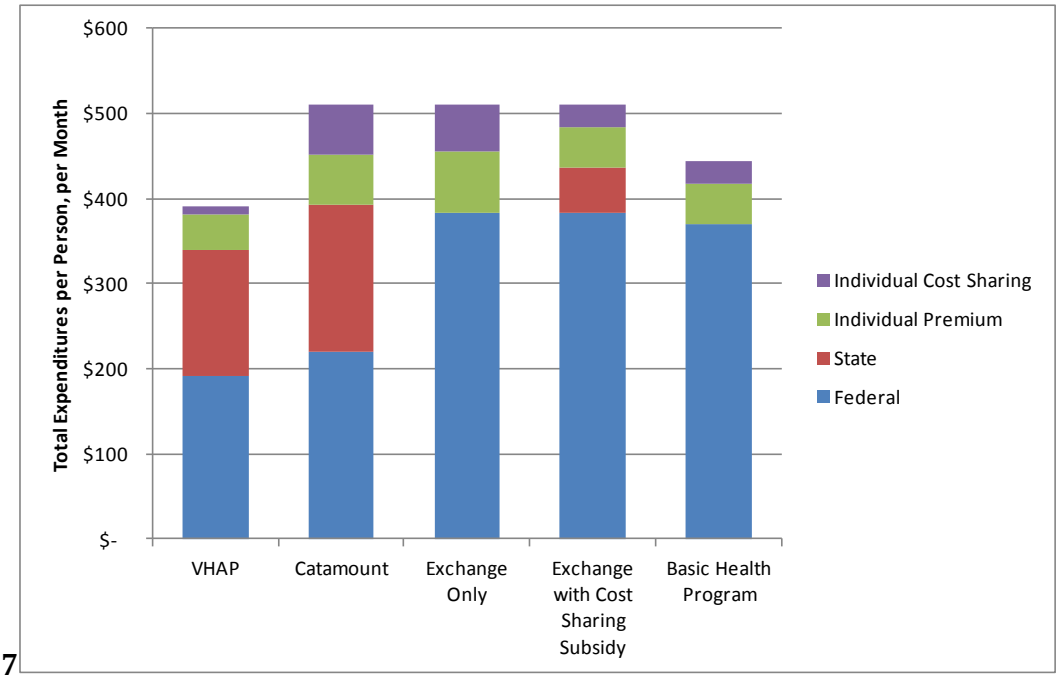


Table 7

As shown in the chart above and discussed previously in this report, if Vermont opted to transition individuals from the existing VHAP and Catamount programs to the Exchange without a state subsidy, individuals currently enrolled in VHAP with incomes above 138% FPL (about 20% of the current VHAP enrollees) would be responsible for an appreciably larger share of costs, and individuals currently enrolled in Catamount may be responsible for a slightly higher share of costs.

If Vermont opts to eliminate or reduce this gap, it could use state-only dollars or seek authority under its Demonstration to secure federal Medicaid match for these expenditures. Based on currently available program expenditure estimates, the total cost of subsidizing individual cost-sharing obligations under the Exchange in order to maintain current VHAP/Catamount cost sharing levels, would be approximately $6 to $8 million. If Vermont is able to secure Medicaid matching funds for these subsidies, State costs would be $2.6 to $3.5 million. ***This is a rough estimate and could change once final guidance on a number of variables is received from the federal government.*** These funds, however, would be available from savings realized by the state from individuals who are currently covered through VHAP and CHAP premium assistance and move into the Exchange.

The federal subsidy level under the Basic Health Program is approximately 95% of the federal subsidy available under the Exchange.[5] The actual value of the federal subsidy under the Exchange (and therefore the Basic Health Program) is difficult to estimate at this point.

Under the Basic Health Program option, Vermont would seek authority to serve individuals under the Global Commitment public managed care model. Vermont could seek authority to use the federal subsidies to make capitation payments to the public managed care entity, much like the Global Commitment financial model operates today. The public managed care entity would be at risk for funding all covered services. Any shortfall would be the financial responsibility of the State. If program expenses are below capitation revenues, Vermont could seek the same authority it has under Global Commitment to invest excess revenues to support its health care delivery system and reform efforts.[6] As discussed above, it is unclear whether this model will be allowed by CMS.

Based on current estimates, federal subsidies meet the public managed care entity's estimated expenses and potentially result in a modest gain of slightly less than $1 million. If Vermont obtains the same authority it has under Global Commitment, excess revenues

[5] Federal law is unclear whether the 95% applies s to both premium and cost-sharing subsidies or the federal subsidy under the Basic Health Program would be 95% of premium subsidies and 100% of cost-sharing subsidies.

[6] Under the ACA, federal subsides available under the Basic Health Program must be used for enrolled individuals or returned to the federal government. However, if the federal subsidy is made as a capitation payment, the federal subsidy would be fully expended even if the public managed care entity achieves some savings.

could be re-invested to lower cost sharing, increase provider rates, or support other health-related initiatives.

Employer-Sponsored Insurance Premium Assistance: Today and 2014

Since November 1, 2007, Vermont has had an Employer-Sponsored Insurance Assistance (ESIA) program for adults with income less than 300% FPL. If someone is eligible for VHAP (income less than 150%, or 185% for adults with children), and the State determines that it is more cost-effective to enroll the person in ESI with premium assistance than to provide coverage under VHAP, the person is asked to enroll in ESI, and the State pays a portion of the employee's share of the ESI premium. VHAP provides wrap-around coverage so that the ESI enrollee has equivalent coverage to VHAP, and cost-sharing that is no higher than the person would pay in VHAP.

If an applicant's income is over the limit for VHAP, but under 300% FPL, and it is more cost-effective for the State to pay premium assistance for the applicant's ESI program than to pay premium assistance for Catamount Health, the person is asked to enroll in ESI, and the State pays a portion of the ESI premium. Enrollees in this category of ESIA receive partial wrap-around coverage for the prevention and maintenance of certain chronic conditions.

To be eligible for either category of ESIA, the applicant must have been uninsured for 12 months, with some exceptions for loss of coverage due to a loss of employment, death of a spouse, or another specified reason.

Currently there are around 800 people in the VHAP-ESIA component and around 750 people in ESIA for the higher-income component. Unfortunately, the state does not have data on how many of these individuals are employed by businesses with less than 50 employees, businesses with less than 100 employees, and businesses with over 100 employees. This makes it difficult to determine how many of these employees may purchase insurance through the Exchange in 2014, because only small businesses may offer insurance to their employees through the Exchange as of that date.

Under the Affordable Care Act, an individual may not buy insurance as an individual through the Exchange if there is an ESI plan available to that individual. There are exceptions if the ESI plan is not affordable or does not meet a minimum value requirement, in which case the individual may buy a plan through the Exchange and receive premium tax credits and cost-sharing subsidies. Individuals who are not eligible to buy insurance through the Exchange as individuals may not receive federal tax credits. If the individual is employed by a small business, however, the employer may offer insurance to the employee through the Exchange. In addition, if the small business elected to discontinue insurance, the individual would be eligible as an individual to purchase insurance through the Exchange with the federal tax credits.

Under these rules, many people who are now eligible for Vermont's ESIA program will no longer be eligible for premium assistance in 2014. This would not be a problem for

people with income under 138% FPL ($1285 for an individual and $1740 for a couple), since those people would become eligible for Medicaid. Under the current federal Health Insurance Premium Program (HIPP), Vermont could continue to pay premiums for ESI plans if it is cost-effective for the State to do so.

In evaluating the impact of ending the current ESIA program, the State should consider that most plans in the small group market will look different in 2014 than they do today.

Plans that have not been "grandfathered" under the ACA, and the number of grandfathered plans will diminish over time as premiums are increased and other changes are made to cost sharing, must meet ACA requirements. For example, the ACA requires plans to include all Essential Health Benefits and limits deductible amounts and out-of-pocket spending. Under the ACA, an employee will not be required to enroll in an ESI plan if the premiums exceed 9.5% of income or the plan's actuarial value is less than 60%.

These changes should result in more comprehensive ESI plans with lower cost sharing, and if these changes cause premiums to increase, employees will have the protection of the 9.5% ceiling. An employee whose ESI premiums exceed 9.5% of income will be free to purchase insurance through the Exchange and receive tax credits if income is less than 400% FPL. In addition, some small employers may choose to discontinue health insurance in order to allow their employees to access federal premium tax credits in the Exchange. In some instances, the premium and cost sharing for employees with the premium tax credit will be more affordable and more comprehensive than what the employer might be able to offer.

Legislative Decision Points in 2012

The Global Commitment to Health waiver expires in 2014 and the state is required to submit in July 2012 a preliminary transition plan for how Vermont's Medicaid programs will comply with the ACA and integrate coverage with the Exchange. In addition, because the long lead time necessary to negotiate a new Section 1115 waiver, the administration must begin this process in the fall of 2012 in order to ensure that final CMS approvals are in place by mid 2013. This legislative session, the general assembly should provide policy guidance to the administration in order to guide the waiver negotiations with CMS going forward. In addition, 33 V.S.A. 1901 requires legislative approval prior to applying for a new wavier or a waiver renewal. The administration requests that the general assembly provide authority to move forward with Medicaid waiver negotiations with CMS.

III. Private Insurance Coverage

Coverage Today

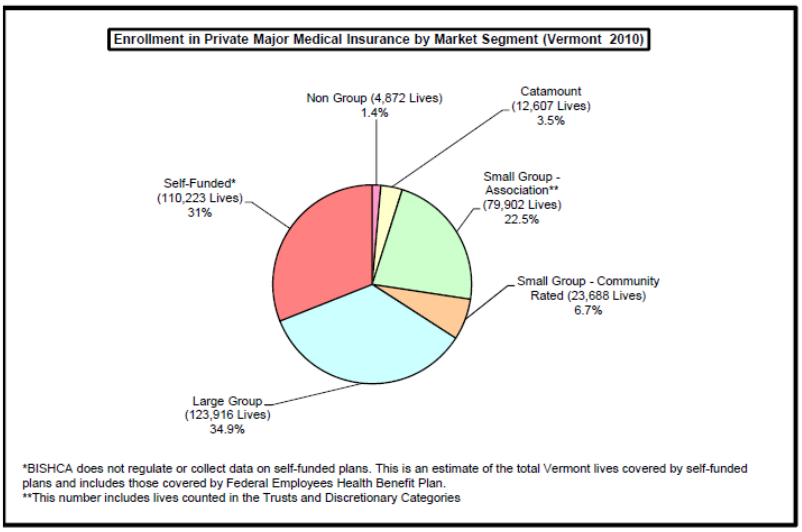


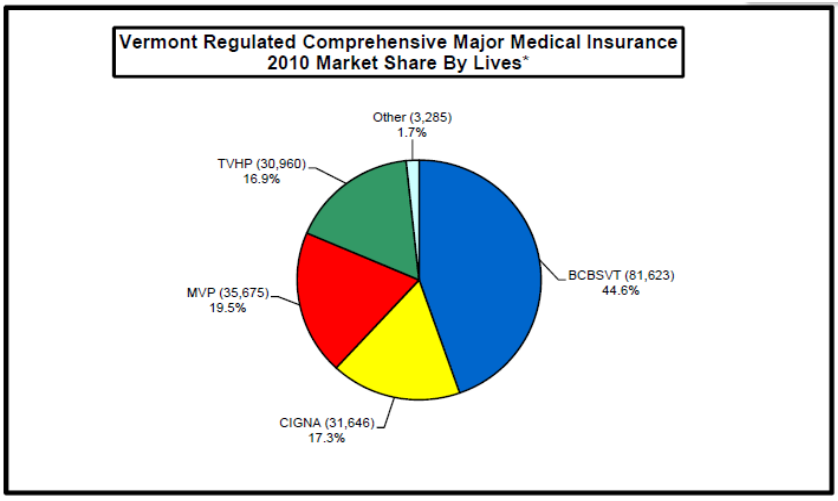
Table 8.

In 2010, the insured non-group market, including Catamount Health was responsible for 17,479 covered lives (4,872 non-group, 12,607 Catamount). The insured small group market was responsible for 103,590 covered lives with 79,902 lives covered by the small group association market and 23,688 lives covered by the small group community rated market. Self-funded employer plans covered 110,223 lives in 2010 while the large group market segment covered 123,916 lives.

In 2010, 183,189 Vermonters were insured by private health insurance regulated by the state of Vermont and 61,796 Vermont lives were covered by health plans licensed in other states. Four insurance companies are responsible for 98.3% of the lives covered by Vermont-regulated comprehensive major medical insurance. These four companies are:

- Blue Cross and Blue Shield of Vermont
- The Vermont Health Plan
- CIGNA
- MVP Healthcare

Across all markets, Blue Cross and Blue Shield of Vermont covered the most lives of any carrier in the state, with a 2010 market share of 44.6% or 81,623 lives.



* - Total enrollment in Private Health Insurance for 2010 in Vermont was approximately 183,189 and does not include 61,796 Vermont Lives covered by health plans licensed in other states.

Table 9.

Insurance Market Compliance with the Affordable Care Act

Act 48, in framing the requirements for this report, set the stage for legislative consideration of specific issues during the current legislative session. Act 48 requires the Agency of Administration to present facts and recommendations to the Legislature on matters that include the following:

Section 8(a)(1)(B):

> (i) The statutory changes necessary to integrate the private insurance markets with the Vermont health benefit exchange, including whether to impose a moratorium on the issuance of new association policies prior to 2014, as well as whether to continue exemptions for associations pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health benefit exchange and if so, what criteria to use.

To establish a statistical baseline for its work, the State commissioned consultant studies of the Vermont population's current sources of health care coverage, segmented by type of insurance and relevant group size (individual, groups of under 50 employee lives, groups of under 100, associations), and other factors. Data was gathered from public sector programs, commercial insurers, and associations. Wherever possible, data was derived at the group (employer) level. To adjust for variations in benefits and rates in the current insurance market, a hypothetical "anchor" plan was derived from existing coverage plans offered in Vermont, and the premium impact of various policy proposals were measured as they would affect the price of this benchmark plan.

With this data, consultants were asked to map out rate increases and decreases that would arise from different combinations of Catamount enrollees, groups of fifty employee lives or less, and groups of 50-100 employee lives.

a. Associations

Vermont's health insurance market for small groups (presently defined to include groups with fifty or less employee lives) is largely comprised of associations --aggregated individuals and employer groups whose coverage is provided by a single organization such as a chamber of commerce. Although these associations can be quite large, Vermont law requires such associations to be rated using small group rules. In states where purchasers do not have guaranteed access to coverage, associations are often the only way for an individual or small business to obtain insurance. In states like Vermont where the right to purchase coverage is guaranteed, however, associations can enable participants a chance to purchase coverage at less cost than in the open market by aggregating employee groups with relatively low utilization or risk factors.

Historically, Vermont's regulation of associations has been inconsistent. Some associations believe they are not permitted to admit groups larger than fifty while others have done so. Some associations have rated member groups consistent with Vermont's small group law but have not merged their members into a single risk pool.

The federal Affordable Care Act (ACA) does not recognize associations as distinct entities and indeed does not mention them at all. Instead, the ACA refers only to employers (small or large) and individuals. The ACA requires that members of an association be considered as what they are: individuals or small group employers or large group employers.

In 2002, CMS issued an Insurance Standards Bulletin stating that for purposes of the Public Health Service Act, "the test for determining whether health insurance coverage offered through an association is group market coverage, or individual market coverage, for purposes of title XXVII, is the same test as that applied to health insurance offered directly to employers or individuals."[7] CMS expressly adopted this interpretation to the ACA in guidance issued September 2011: "the test for determining whether association coverage is individual or group market coverage for purposes of Title XXVII of the PHS Act is the same test as that applied to health insurance offered directly to individuals or employers. Association coverage does not exist as a distinct category of health insurance coverage under Title XXVII of the PHS Act." [8] So, as to coverage, "each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer."

The federal government takes the same approach to rate review under the ACA: "Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage. . . . Coverage that would be regulated as small group market

[7] CMS Insurance Standards Bulletin Transmittal No. 02-02 (August 2002) at 2.
[8] CMS Insurance Standards Bulletin Series—INFORMATION; **Subject:** Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations (September 1, 2011)

coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage."[9]

Since the ACA requires each insurer to merge all its small groups into a single rating pool, groups within associations today may experience significant rate changes when these groups are rated together with other elements of the small group market.

Members of association groups that have successfully attracted groups with better health experience than the general small group population will experience the greatest price increases. Conversely, traditional small groups who have purchased coverage on their own will see corresponding rate decreases as the rate burden of groups in and outside of association is equalized.

Today's association-based small groups could be tomorrow's Vermont Exchange participants. Ending the ability of small employers to access health insurance through associations would add approximately 32,000 to 37,000 members who could purchase insurance through the Exchange.

It is important to bear in mind that any proposed reallocation of rates intends a shifting of burden among market participants without changing the aggregate cost to the entire market. As in a consideration of community rating, relative responsibilities are realigned without impacting total spending.

Recommendations
The State must comply with the Affordable Care Act. The administration, therefore, recommends amending Vermont statute to eliminate associations for the purposes of rating health insurance coverage in 2014 as required. Such a change would permit individuals and small groups formerly rated with associations to purchase coverage in Vermont's Exchange beginning in 2014—and pay the same rate charged by an insurer to all other small groups buying the same coverage. Any large groups currently part of an association would, at least until 2017 when they would be eligible to purchase in the Exchange or until implementation of Green Mountain Care, find coverage in the traditional commercial insurance market. We do not recommend an immediate moratorium on associations.

b. Defining Small Groups: 50 vs. 100 employees

Current Vermont law defines a small group, for the purposes of health insurance coverage, as a group with fifty or fewer employees and their dependents. The ACA defines such a group to include one hundred or fewer employee lives effective 2014, but gives states the option to redefine small groups to include up to fifty employee lives until 2016. In 2016, the state must define small group as an employer with 100 employees or fewer. This definition applies to the entire small group – not just the Exchange as is commonly misinterpreted.

[9] 45 CFR 154.102 (eff. November 1, 2011).

The ultimate size of the Exchange-eligible population is dependent upon policy decisions currently being considered by the general assembly; specifically, those related to the definition of small group size as well as the status of employer groups currently purchasing through an association plan. Table 10 illustrates the potential impact of increasing the definition of small group to 100 employees and requiring association members to purchase coverage on the basis of their individual group size characteristics as required by the ACA. As illustrated in this table, expanding the definition of small group would increase the size of the Exchange-eligible population by 15,000 members, while including membership from association plans would increase the Exchange-eligible population by between 32,000 and 37,000.

Table 10. Estimated Size of Exchange-eligible Population under Different Policy Scenarios

	Not Including AHP Members		*Including AHP Members*	
	SG = 1-50	*SG = 1-100*	*SG = 1-50*	*SG = 1-100*
Non-Group	28,000	28,000	28,000	28,000
Uninsured (Tax Credit Eligible)	29,000	29,000	29,000	29,000
Uninsured (Not Tax Credit Eligible)	10,000	10,000	10,000	10,000
Total Non-Group	**67,000**	**67,000**	**67,000**	**67,000**
Small Group < 50	24,000	24,000	24,000	24,000
Small Group 51 – 100	0	15,000	0	15,000
AHP < 50	0	0	32,000	32,000
AHP 51-100	0	0	0	5,000
Total Small Group	**24,000**	**39,000**	**56,000**	**76,000**
Total Exchange Eligible	**91,000**	**106,000**	**123,000**	**143,000**

The definitional choice of small group size is closely related to the decision about the future of associations. Together, they will define the universe of small groups eligible for Exchange participation and therefore the upper and lower size limits of Vermont's SHOP Exchange. Increasing the definition of small group to 100 would, by itself, modestly increase the potential size of the Exchange by 15,000 members or 16% but is less significant than the policy question regarding the future of association health plans.

The potential population of the Exchange will have important implications on a number of issues:

- Self-sustainability of the Exchange: Successful administration of an insurance program is significantly influenced by the ability to spread risks and the program's administrative costs over a larger number of insureds;
- Desire of carriers to become issuers of QHPs: insurers also seek to the administrative advantages of selling products to larger numbers and spreading risk over a largest population possible;
- Ability of the State to drive provider change through its Exchange: providers are more willing to accept externally-imposed policies if they can apply them to a large number of patients as opposed to a fragment of those under their care.

The ACA requires that in 2014 all small group plans, whether sold inside or outside a SHOP exchange, comply with distinct cost-sharing ratios (the so-called "metal" plan levels) and include an array of essential benefits to be determined by each state. Because all small group plans must comply with the actuarial values established by the "metal" levels, the amount of variation in plans, whether sold by the Exchange or by a broker, will be limited.

For employees, a small group definition of 100 or less (rather than 50 or less) makes the Exchange available to approximately 32,000 additional Vermonters. Members of groups purchasing in the Exchange are not entitled to tax credits, so the difference between being insured inside or outside the Exchange will be significant only if there is an outside-the-Exchange market where a different selection of products is allowed.

Employers' alternatives in and outside the exchange are also limited, but employers in the Exchange may be eligible for limited employer tax credits.

For the State the administrative and public policy drivers that favor a purchase of small group plans within the Exchange are these:

- The more persons purchasing in the Exchange, the better its ability to spread risk among its participants and the less per capita operating overhead for what the ACA requires to be a "sustainable" market;
- Merging more groups and types of groups into the Exchange brings Vermont closer to its goal of equitable Green Mountain Care for all;
- Simplification of plan offerings allows greater clarity and transparency for the small businesses when they choose coverage.

The continued existence of ways to differentiate coverage—especially when these differences become minimal or cosmetic since the ACA will not permit more material variation—would be primarily ways to steer people into higher-risk and lower-risk groups. This process of adverse selection results in churning of Vermonters through different forms of coverage without any net benefit to the overall population.

Recommendations

Small groups should be defined as employers with 100 employees or less, and the Exchange should be a mechanism for purchasing insurance in the individual and small group market.

c. Plans Allowed Inside and Outside the Exchange; "Qualified" and "Unqualified" plans

Section 8(a)(1)(B) requires that the administration recommend:

> (iii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing qualified health benefit plans to be sold to individuals and small groups both inside and outside the Vermont health benefit exchange.
>
> (iv) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing nonqualified health benefit plans that comply with the provisions of the Affordable Care Act to be sold to individuals and small groups outside the exchange.

To provide actuarial and policy guidance about these interrelated market decisions, the State has engaged the Wakely Consulting group. Wakely Consulting has integrated earlier studies and developed a picture of the Vermont insurance market and its possible responses to the potential changes referenced above.

There are three options for structuring the small group market under the ACA:

Option A: Allow both "qualified" and "non-qualified" small group health plans to be sold outside the Exchange

Option B: Allow only "qualified" small group health plans to be sold outside the Exchange

Option C: Require the sale of small group, fully insured health insurance products exclusively through the benefit Exchange

Each of these options will be evaluated from the perspectives of the state, the Exchange, employers and individuals or employees. Before looking at each of these perspectives, this section will discuss who is eligible to purchase coverage in the Exchange in 2014 and estimates of these populations.

Size of the Markets

Those eligible under the federal ACA to purchase coverage in an Exchange in 2014 include individuals without access to employer-based coverage (whether uninsured or currently purchasing individual coverage today) and members of small employer groups.

Table 11. Estimated Size of Exchange-eligible Population Based on Current Market

Non-Group	28,000	31%
Uninsured (Tax Credit Eligible)	29,000	32%
Uninsured (Not Tax Credit Eligible)	10,000	11%
Total Non-Group	**67,000**	**74%**
Total Small Group	**24,000**	**26%**
Total Exchange Eligible	**91,000**	**100%**

Based on the current composition of the market and Vermont's current definition of small groups (50 employee lives or less), uninsured individuals, as well as those currently buying insurance in the small and non-group insurance markets would be eligible to purchase through the Exchange. A detailed break-out of these population groups is illustrated in Table 11 above. As indicated in the table, approximately 91,000 people would be eligible to enroll in the Exchange based on current market definitions and assuming no other changes (such as changes of employer offer rates or coverage practices). The 91,000 Exchange-eligible persons represent 27% of the current commercially insured market. Of this total, roughly a quarter, or approximately 24,000, are currently covered in the small group market.

Analysis from Exchange Perspective
Each of the three options describe above will be analyzed from different perspectives. The chart below illustrates the considerations for the Exchange:

	Option A (Base Case)	**Option B (Uniform Standards)**	**Option C (Only Exchange)**
1. Exchange Sustainability	Tax credits may not ensure substantial take up by small groups Historically, small groups slow/reluctant to purchase through Exchange, take credits	Greater uniformity between inside/outside market may reduce incentive to remain outside Exchange, increase enrollment	Maximize the number of small groups purchasing through the Exchange

2. Adverse Risk Selection	ACA risk programs in place Residual potential selection from consumer choice, different standards in/out of exchange, carrier marketing Carriers subject to uncertainty related to ACA program affects	Should neutralize majority of residual selection risks Small residual potential based upon consumer choice, carrier marketing	No selection risk based on inside/outside dynamic Federal risk corridors protect all plans from market-wide selection effects for 2014 - 2016
3. Administration and Implementation			Sole distribution option may increase service-level demands, raise bar for implementation, and require more robust functionality (Enrollee choice option, hands-on account mgmt)

Table 12.

Although not necessarily predictive of employer behavior in Vermont, examples from other states suggest that, without stronger incentives of regulatory compulsion, the share of Vermont's small employers likely to purchase insurance through the Exchange may be quite small. And, as a substantial component of the potential enrollment base for the Exchange, this may have an impact on the size, sustainability, and market influence of the Exchange. From the perspective of the Exchange, Option C provides the greatest assurance that there will be a robust take-up of insurance through the Exchange.

Analysis from State's Perspective

The following chart illustrates the considerations from the perspective of the state:

	Option A (Base Case)	Option B (Uniform Standards)	Option C (Only Exchange)
1. Integration with Vermont Health Reform Initiative	Potential for lower enrollment scale may limit market reach of Exchange, reduce scope of Exchange as "test-run" for Green Mountain Care	Expands reach of Exchange into employer market by creating uniform standards To the extent standards cover delivery system reforms, payment reforms, etc., could help with transition to GMC	Greatest reach and influence of Exchange Maximizes the share covered under unified and uniform health system prior to transition to Green Mountain Care
2. Level of Regulatory Oversight	Potentially sets up dual regulatory processes, with QHP certification, Exchange rate review running in parallel to existing processes Different markets need to be treated somewhat differently in risk adjustment application	Increases oversight requirements for existing market, but creates greater uniformity between Exchange and outside market Ongoing coordination required to make sure outside regs reflect Exchange certification criteria	Eliminates the need for dual processes due to unified market Single settlement process applied to all plans for risk adjustment

Table 13.

The ability of the Exchange to provide the desired foundation for the significant changes contemplated in Vermont will be affected by the scale and stature of the Exchange during the transitional period from 2014 to 2017. The changes contemplated in Vermont's legislation are far reaching and include the implementation of payment and delivery system reform, all-payer rate setting, and several other initiatives. Successfully initiating these reforms in the transition period will require an organization with significant market presence and stature. Similarly, the transition in 2017 from the Exchange to Green Mountain Care will be made smoother to the extent that the Exchange, in which many of

the state's reforms will have been "test-driven", comprises a substantial portion of the existing insurance market. As highlighted above, the stature, scope, and relative market influence of the Exchange will be limited to the extent that small groups elect not to purchase through the Exchange. Consolidating markets within the Exchange, on the other hand, will provide a larger base and more significant market reach in preparation for the state's larger health reform initiative.

Option C would provide the greatest reach to the Exchange in beginning the implementation of health reform initiatives, and would also do the most to ease the transition to Green Mountain Care, as it would maximize the share of those already covered within a unified and uniform health system, i.e., the Exchange.

Analysis from Purchaser Perspective
The following chart (Table 14) looks at the issue of whether to offer plans "outside" of the Exchange from the perspective of purchasers:

	Option A (Base Case)	**Option B (Uniform Standards)**	**Option C (Only Exchange)**
1. Product Choice	Does not limit overall product choice available in market, but still must meet ACA benefit standards Increases likelihood of some different product offerings (potential selection issue)	Impact on product choice depends on QHP certification strategy, product requirements	Exchange has critical role in determining level of product choice in the market Depending upon QHP certification approach, could limit overall level of choice in the market to a number of options
2. Distribution Channel Options	Least disruptive to existing distribution channels	Little difference relative to Option A related to distribution options	Exchange becomes sole distribution channel Impact depends on approach to working with brokers/agents May create additional service demands on Exchange

3. Potential Movement to Self-Insured Status	Base option unlikely to spur desire to become self-insured beyond motivations that may result from ACA implementation generally	Little difference between Option A and Option B, although may create some additional interest based on potential constraints in product choice	For employers wary of working with state entities, concerned about premium impact, or desiring greater choice, may encourage consideration of self-insured status

Table 14.

The potential impact of this decision that is particular to employers and employees will likely be on the purchasing experience; i.e., the level of choice in products and carriers, as well as their options related to different channels for purchasing insurance. Also to the extent employers are allowed to become self-insured through creative reinsurance programs, employers may elect to remain outside the small group market until such time as their experience-rated cost is as great as or greater than the small group risk pool average.

An important consideration is the level of choice available to employers and employees in terms of insurance products and benefit designs, as well as the ability of carriers to develop or adjust benefit designs to meet changing market demands, either in aggregate or related to a specific client. More choice, however, also means less simplicity and standardization for the consumer. From engaging with employers of the summer and fall, it appears that many employers are looking for a balance between these two issues.

In addition, many small employers rely upon brokers to compare benefit plans, initiate enrollment, manage their account, purchase ancillary services such as life and home insurance products, and perform other administrative and payroll functions related to the maintenance of coverage. In deciding whether to require all employers to purchase through the Exchange, accounting for current employer purchasing patterns and options for purchasing, enrolling in, and administering their coverage will be critical considerations for working with small employers. This will create the need to either include brokers in the sales and enrollment process or otherwise provide a comparable level of service to small groups, who often have fewer resources and require greater levels of assistance in acquiring and maintaining coverage. This will be especially important post-sale, when many customer services functions that are not easily IT-enabled are handled by broker or other producers.

Qualifications of Health Plans

Federal requirement	Current Vermont law
Marketing may not discourage enrollment of individuals with significant health needs	Some marketing review as part of form review
Network adequacy & services area	Network adequacy requirements
Transparency	Transparency (new Act 48 requirements)
Essential Community providers & access for underserved populations	FQHCs commonly in networks now
Quality measures	Rule H-2009-03 (formerly rule 10)
Satisfaction Surveys	Managed Care insurers, yes

Table 15.

Recommendations*:*

- Insurance plans for small groups and individuals should be sold solely through the Exchange in order to increase Exchange sustainability and promote payment reform and other health care reform.
- Insurer designs should be solicited prior to finalizing Exchange plan options.
- In designing recommendations for the Green Mountain Care Board, the administration should ensure that choice and standardization are balanced.

Actuarial Analysis

The impacts on premium rates of disaggregating associations and equalizing the rates of all Vermont individual and small group insureds is shown in the following two charts. The first illustrates the percentage impact on each group from merging the individual

market with the Catamount market, with merging the association market with the small group market (defined as businesses with 50 employees or less), and of merging those markets into one pool. The second illustrates the same information using an small group market definition of businesses with 100 employees or less.

Two associations are not included in this analysis at this time, because of data problems that have not yet been resolved. One of these groups is VEHI, the trust which provided insurance to the education employees. The data available from the insurers does not reflect groups broken down by employer size, so it was unable to be merged with the other information. The administration has sought assistance from VEHI and NEA to adjust the data to reflect employer sizes so that it may be included at a later date.

Table 1.a. Impacts of Market Mergers in 2014

Impact of Merging Markets with Contract Tier Normalization (Excludes VEHI & VADA)					
Table 1.a. - Scenario 1: Small Group Defintion Up to 50					
Pool	Merge Association & SG	Add Catamount to Individual	Add VHAP to Individual	Merge Individual & SG	Scenario 1 Cumulative; SG Definition to 50 Lives
Individual	0.0%	-11.2%	3.1%	-4.3%	-12.4%
Small Group < 51	-9.9%	0.0%	0.0%	1.7%	-8.4%
Group 51 to 100	0.0%	0.0%	0.0%	0.0%	0.0%
Large Group 101+	0.0%	0.0%	0.0%	0.0%	0.0%
Total: 51 to 101+	0.0%	0.0%	0.0%	0.0%	0.0%
Association < 51	16.3%	0.0%	0.0%	1.7%	18.4%
Association 51 to 100	0.0%	0.0%	0.0%	0.0%	0.0%
Association 101+	0.0%	0.0%	0.0%	0.0%	0.0%
Total: Assoc 51 to 101+	0.0%	0.0%	0.0%	0.0%	0.0%
Self Insured	0.0%	0.0%	0.0%	0.0%	0.0%
VHAP 133% + FPL	0.0%	0.0%	34.7%	-4.3%	29.0%
Catamount	0.0%	24.4%	3.1%	-4.3%	22.8%
Total	0.0%	0.8%	1.1%	0.0%	1.9%

NOTE: Catamount enrollees and VHAP enrollee impacts do not include the offset of decreased premiums from the federal premium tax credit or any state subsidy offered for lower-income purchasers. In addition, the actuarial analysis assumes that claims would be paid at commercial reimbursement rates, not at the lower reimbursement rate set in Vermont statute, which is responsible for a significant portion of the impacts. These

impacts assume all rates move to the current commercial rate and do not reflect any adjustment to commercial rates from a reduction in the cost-shift.

Table. 1.b Same Analysis, except Small Employer Defined as 100 Employees or Less

Impact of Merging Markets with Contract Tier Normalization (Excludes VEHI & VADA)			
Table 1.b. - Scenario 2: Small Group Defintion Up to 100			
Pool	Cumulative Change from Scenario 1	Change Due to Merging 51-100 and Ind-SG	Scenario 2 Cumulative Change
Individual	-12.4%	0.0%	-12.4%
Small Group < 51	-8.4%	0.0%	-8.4%
Group 51 to 100	0.0%	7.4%	7.4%
Large Group 101+	0.0%	-2.4%	-2.4%
Total: 51 to 101+	0.0%	0.0%	0.0%
Association < 51	18.4%	0.0%	18.3%
Association 51 to 100	0.0%	3.9%	3.9%
Association 101+	0.0%	-2.0%	-2.0%
Total: Assoc 51 to 101+	0.0%	0.0%	0.0%
Self Insured	0.0%	0.0%	0.0%
VHAP 133% + FPL	29.0%	0.0%	29.0%
Catamount	22.8%	0.0%	22.8%
Total	1.9%	0.0%	1.9%

See Notes above.

c. Impact of Exchange Participation for Specific Groups

1. Municipal employees

Municipalities that purchase health care coverage for their employees include not only cities and towns but also school districts and other types of public sector entities. Approximately 400 Vermont municipalities purchase coverage, of which perhaps half belong to the Vermont League of Cities and Towns. Of these groups, only a very few have more than 50 members (25 is an estimate), but these larger groups may represent as many as 50% of municipal employees.

Prior to 2012, VLCT offered health insurance plans to municipalities as an association but with an association exemption from Vermont's small group insurance rules. In 2012,

VLCT members will be purchasing insurance in the small or large group depending on the size of the municipality. Under current law, small group is defined as an employer with 50 employees or less, so towns with 50 or fewer employees are purchasing in the small group. Towns with more than 50 employees (less than ten groups) are purchasing in the large group market. VLCT is working with a broker to assist members in choosing insurance. This change was made because towns no longer received a financial benefit from being rated as an independent pool and merging into the small group market became financially beneficial. Because this change was made recently, the impacts of this change are not reflected in the premium rate changes provided above.

When municipalities purchase in the small or large group markets, they are subject to the same changes as other businesses in the small or larger group markets in 2014. This means that the definition of small group will have an impact on towns, because it will determine which market they will purchase in. Additionally, the decision on whether small group plans may only be purchased within the Exchange will have an impact on how towns purchase insurance.

Recommendation:
There is no legislative action required at this time to include municipal employees in the small group market.

2. Education employees

Many employees of school districts purchase health insurance through the Vermont Education Health Initiative (VEHI). VEHI is described as a "member association" on the Secretary of State's website and is commonly described as an "association" for insurance purposes.

In 2010, BCBSVT reported 20,000 subscribers and 40,000 lives in VEHI. There are 111 distinct groups with 36 groups having fewer than 50 subscribers, 21 groups with subscribers between 50 to100, and 54 groups with over 100 subscribers. This information does not necessarily correspond with the total number of employees in a district and may not accurately reflect whether the district would purchase in the small or large group markets.

VEHI operates a trust for the purchase of health insurance for its members and deposits premiums received from school districts and their employees into this trust. VEHI currently offers health plans from Blue Cross Blue Shield of Vermont on a "cost-plus" basis. A "cost-plus" plan is regulated as an association plan, but the purchaser (in this case, VEHI) pays for the members' claims and an administrative fee, similar to a self-insured employer with a third-party administrator. Each school district, however, does not pay claims as they accrue, but instead pays a premium into the trust. In addition, VEHI purchases reinsurance from BCBSVT. Employees, however, hold BCBSVT identification cards and subscriber certificates, which is not typically the case when an employer is self-insured. In addition, as noted above, the insurance products are otherwise regulated as association products, including insurance benefit requirements.

VEHI does not purchase a traditional insurance product, because VEHI pays claims plus an administrative fee and has reinsurance. On the other hand, VEHI is not really self-insured, because BCBSVT follows association rules, school districts pay premiums, and employees have insurance cards and policies. In summary, the historical arrangement provided to education employees seems to be virtually unique.

School districts, as association members, will be unable to purchase insurance as a distinct group, because the state must comply with the ACA rating provisions described in the previous section, provisions which expressly disregard associations and treat employers and individuals as what they are. There is an important exception in the ACA, however, which applies to many of the insurance plans offered in 2012 by VEHI. Under some circumstances the ACA allows employers to retain insurance plans if the plans meet certain tests and become so-called "grandfathered" plans. While the actual provisions are somewhat complex, they can be briefly summarized as follows.[10]

First, the ACA exempts from certain requirements coverage maintained pursuant to one or more collective bargaining agreements ratified before enactment of the ACA on March 23, 2010. This grandfathering provision applies until the last of the collective bargaining agreements terminates. An amendment to a collective bargaining agreement solely to conform to the ACA does not terminate the agreement for purposes of grandfathering.

More generally, a plan is grandfathered unless any one of the following occurs:

(i) Elimination of all or substantially all benefits relating to a particular condition;
(ii) Any increase in percentage cost-sharing requirements, such as an individual's coinsurance requirement;
(iii) An increase in a fixed-amount cost-sharing requirement other than a co-payment, such as a deductible or out-of-pocket limit, that exceeds an allowable increase determined by a formula set out in the regulation;
(iv) An increase in a fixed-amount copayment if the increase exceeds an amount allowed by formula;
(v) A decrease in employer contribution that exceeds certain limits; and
(vi) Changes in annual coverage limits, including imposing such a limit where there was none before March 23, 2010, or decreasing such limits.

Of the approximately sixty-five relevant health insurance products approved for sale in Vermont at the present time, only thirty still have grandfathered status under the ACA. This number will continue to decrease over time as the remaining grandfathered plans are amended.

Once the VEHI health benefit plans no longer meet the legal requirements for grandfathered plans, school districts would purchase insurance in the appropriate market, depending on size and the definition of small group chosen by the general assembly. So, districts that meet the definition of small group would purchase in the small group

[10] The specific requirements are set out at 45 CFR 145.140 (eff. November 17, 2010).

market. Districts that meet the definition of large group would purchase in the large group market and would be excluded from the Exchange until 2017.

Recommendation:
No legislative action is needed at this time.

3. Self-Employed

Currently in Vermont self-employed individuals may purchase insurance in the small group market. Under proposed rules issued by the federal government, beginning in 2014, self-employed individuals will not be eligible to purchase small group plans. Although transitioning from the small group to the individual market would mean in today's environment that the self-employed individual would pay a higher premium, this impact will be mitigated in 2014 by the availability of premium tax credits and cost-sharing subsidies for individuals with income under 400% FPL. In addition, if the individual and small group markets are merged, premiums in the individual market will be community rated in a much larger pool, resulting in a 10.7% premium reduction from 2010 levels (assuming Catamount enrollees no longer receive their current state premium subsidy)**.** If the state offers a Basic Health Program or a state wrap-around subsidy, this group would further benefit.

Recommendation: The state is required to comply with the ACA and must conform its small group definition to exclude self-employed individuals. This group would benefit from the merger of the individual and small group markets and from purchasing within the Exchange in order to access federal premium tax credits and cost-sharing subsidies.

4. Self-Insured Employers

Self-insured employers' purchase of insurance is regulated by the federal Employee Retirement Income Security Act (ERISA) and not by state law. There are no self-insured groups with 50 employees or less in Vermont. Data on self-insured plans is not readily available. The Vermont Department of Labor reports that in early 2011 96.6% of all businesses in the state had less than 50 employees, 1.9% had 50-99 employees, and 1.6% had 100 or more employees. Nevertheless, it is generally believed that there are very few self-insured businesses with less than 100 employees because a small enterprise could so easily be bankrupted by the cost of an employee's catastrophic health care event.

There is some concern that employers with more than 50 employees could choose to become self-insured if the small group definition is set at 100 employees or less. The State, however, will be required to move to this definition in 2016, so if this is a trend employers will use, then it will occur sooner or later.

In order to counteract this trend, the Exchange should be designed to provide value to employers and to be attractive to employers in this size range. The Administration has been reaching out to employers of all sizes to provide them with information about the Exchange and to determine what features would be attractive to employers. The

preliminary efforts, which are on-going, have determined that employers largely do not have sufficient information about the Exchange and the insurance market changes required by the ACA, so are not yet at a point where they can provide input into what would be attractive. A primary concern, of course, is affordability and simplicity. Employers like the idea of giving their employees choices, but worry that this will increase questions for the human resource departments or owners. This worry can be alleviated by a robust navigator program using individuals with specific training on how to work with businesses (including licensed brokers who are interested in participating) and robust 21st century customer service.

To further engage with employers, the administration included in its Level 1 Implementation grant request funds to contract for an employer outreach plan and for focus groups with employers to ensure Exchange design is attractive to employers.

In addition, Act 48 provides authority for the Exchange to offer services to self-insured employers on a voluntary basis. These services could include offering the web portal for enrollment into a self-insured employer's plan choices, offering wellness program administration to self-insured employers, or offering other services currently offered by a third-party administrator. The timeline for establishing these options is under development and largely depends on the information technology procurements. Vermont has an ambitious information technology agenda, which will need to be staged in order to ensure that the systems are well-designed and well-built.

Recommendation: There is no legislative action required at this time. The Administration will continue to engage and work with employers to ensure that the Exchange design will be attractive to business.

5. Large groups

The ACA does not permit large groups—groups outside the small group definition—to purchase insurance products through the Exchange before 2017. Act 48 provides authority for the Exchange to offer services to large employers to the extent allowed under federal law. These services could include offering the web portal for enrollment into a large employer's plan choices, offering wellness program administration to large employers, or offering other services currently offered by a third-party administrator. The timeline for establishing these options is under development and largely depends on the information technology procurements. Vermont has an ambitious information technology agenda, which will need to be staged in order to ensure that the systems are well-designed and well-built. Large group participation would be provided for in 2017, however, under Act 48, the secretary of administration is directed to seek a waiver from the Exchange as soon as it is available from the federal government. Under current law, a wavier is available in 2017 and, additionally, there are bills pending in Congress to modify this date to as early as 2014. It is likely that large employers will become part of Green Mountain Care and need not take the intermediate step of purchasing insurance in the Exchange.

Recommendation: No further legislative action is required at this time.

6. Medicare

Under federal law, Medicare is not an insurance product and thus would not be offered in the Exchange. Act 48 provides authority for the Exchange to offer services to Medicare enrollees to the extent allowed under federal law. One service that might be of assistance to Medicare enrollees would be access to a web portal to enroll in supplemental insurance offered to Medicare enrollees. The range of possible services is being researched and requires additional information from the federal Department of Health and Human Services (HHS) to determine their viability. Otherwise, Medicare will not be integrated into the Exchange. Integration of Medicare into Green Mountain Care is discussed in a different report.

Recommendation: No further legislative action is required at this time.

Exchange and Administrative Simplification

1. Administrative Simplification Opportunities

The Administration envisions that substantial administrative simplification will be obtained over time through alignment of Medicare, Medicaid, and other public programs with the health benefit programs made available through the Exchange under the ACA. In addition, further administrative simplification opportunities would result from aligning administration of enrollment services and other "back end" functions for private employers' self-insured plans, large group plans – including state employees, and potentially supplemental insurance plans and Workers' Compensation insurance plans in the AHS Enterprise Architecture in which Vermont's Exchange will operate.

More specific details about the Information Technology (IT) infrastructure for the Exchange are contained in a separate Report responsive to Sec. 10 of Act 48, but at a summary level, the Administration has designed the Exchange to "sit inside" the larger IT framework that supports health reform as a whole. As such, the Exchange will utilize core system components that will be shared with other elements of the health reform and health information technology (HIT) Portfolio of systems. These include:

- VIEWS (Vermont Interactive Eligibility Workflow System), the new public benefits Eligibility and Enrollment (E&E) system that will replace the current ACCESS system,
- MES (Medicaid Enterprise Solution), the replacement for the Medicaid Management Information System (MMIS),
- VHIE (Vermont Health Information Exchange), the network for clinical data exchange operated by Vermont Information Technology Leaders (VITL) on behalf of the State, and
- Shared AHS Enterprise Architecture components such as the Rules Engine, Workflow Engine, Identity Management services, and Enterprise Service Bus.

This design architecture will itself lead to administrative simplification in the maintenance and operation of the state infrastructure, consistent with the federal guidance issued in April 2011 on the Seven Standards and Conditions for CMS-financed IT systems.

The CMS IT standards include requirements for modularity, open interfaces, interoperability, and reusability that are well matched to Vermont's approach to design and implement the Exchange and other Portfolio components. These IT systems will meet the State's near-term needs to operate the Exchange and have the capacity to be reconfigured and reused to operate in the long term as a single, common system.

A key near-term opportunity arises from the construction of the common Enterprise architecture and its identity management services. These services ensure the ability to reliably track and identify individuals across disparate IT systems. Currently, there is not consistent identity management across the 285 disparate AHS IT systems, nor – of course – between the State's systems and those of commercial insurers or between billing and claims and clinical IT systems.

Vermont, in collaboration with CMS, is leading the nation in developing an infrastructure to enable common identity management across clinical and administrative domains, utilizing the Health Benefits and Health Information Exchanges, linked by the AHS Enterprise Service Bus and its Master Persons Index and State Master Provider Directory.

That common, interoperable standard for identity management will not disclose inappropriate information to those not authorized to see it. Rather, it will enable the IT systems to confirm and link individuals' identities across disparate systems so that when authorized access is obtained, the systems of record will interoperate appropriately. It will also provide a complete audit trail of all transactions in the system, and enable updated information (a change of address, for instance) to flow across the enterprise so that disparate source systems can update their records.

This has the potential to significantly reduce the kinds of administrative errors and delays introduced by typos, misspellings, transposed numbers, and out-dated information. What this could mean in operation is that all benefits programs and insurance plans that interact with the Portfolio infrastructure, as well as providers accessing health information through the VHIE, would ultimately, effectively share a common set of confidential information about individuals, providers, and benefits plans that can be kept up-to-date even as they continue to reside in separate systems.

Thus, the benefits of a centralized system (having the phone number or email address or insurance benefit number correct) can be obtained across multiple, discrete, non-aggregated IT systems. So insurance information is kept separate from clinical information, but it can be correctly linked when it comes time to submit a claim, make a payment on a coverage plan, or switch enrollment to a different plan or different provider.

The Administration envisions that through use of a "smart" benefits card or other second-factor authentication system, individuals would validate their identity across these systems, enabling significant automation of administrative functions and dramatically reducing the number of requests for duplicate information as individuals move across and around the health care system, whether it is when they are visiting a provider's office or when they visit the Exchange to obtain coverage.

Thus, in summary, one of the principle opportunities for administrative simplification rests with building an IT infrastructure that enables identity management across systems.

In addition to technology based opportunities for administrative simplification, there are process-related opportunities. These have a long history, dating back to the health reform legislation enacted under Act 191 in 2006. The Health Care Administration at BISHCA was required to undertake a claims administrative reform initiative. This was only one of several other system comprehensive reform projects that were designed to address systemic changes to health care costs and infrastructure in Vermont, which included Blueprint for Health, multi-payer data collection (VHCURES), price and quality transparency, to name a few. The Common Claims and Procedures Work Group was convened in mid-2006 and identified a seven-point work plan where significant opportunities existed to reduce claims administrative inconsistencies and cost. These included:

- Standardization of Member Identification Card and Maximization of Electronic Transactions
- Simplification of Explanation of Benefits and Patient Bills
- Pilot Electronic Prior Authorization Process
- Standardization of Provider Credentialing
- Improvement of the Efficiency of Claims Adjudication
- Simplification of Workers Compensation Claims Adjudication

The Common Claims and Procedures Work Group consisted of insurers, facilities, and providers working together to recommend changes for the seven key simplification opportunities listed above. A final report was issued by the workgroup on January 8, 2008, and was accepted by BISHCA the following month to begin the rule-making process and to implement the recommendations in the report, except for those related to Workers Compensation for which BISHCA does not have jurisdiction.

BISHCA established the Vermont Claims Administration Collaborative (VCAC) in the Fall of 2008 to implement the recommendations fromt the Common Claims and Procedures Work Group. It included representatives from insurers and managed care organizations, providers, Vermont Association of Hospitals and Health Systems, consumers, patient advocates, DVHA, theVermont Medical Society, Office of Health Care Ombudsman, and a business representative. As a result, the following rules have been adopted (Table 16):

Rule No. H-2008-04 Administrative Claim Requirements		Rule Adoption Date	Implementation Date(s)
Section 6 (1)	**Standards for Explanations of Benefits (EOBs)**	Feb. 1, 2010	Effective on October 1, 2010
Section 6 (2)	**Standards for Patient Bills**	Feb. 1, 2010	• Effective on January 1, 2011 for all hospitals, FQHCs and provider practices with three or more licensed health care practitioners shall implement these standards on or before. • Effective July 1, 2011 for all other providers
Section 6 (3)	**Standards for Member Identification (ID) Cards**	April 1, 2010	Effective upon policy renewal or upon any request for an ID Card replacement after April 1, 2010
Section 6 (4)	**Standards for Mid-Level Practitioner Billing**	April 1, 2010	Effective on July 1, 2010
Section 6 (5)	**Standards for Electronic Prior Approval**	April 1, 2010	Effective on January 1, 2011

Table 16.

Since the rules outlined above were adopted in April 2010, VCAC has been inactive due to other priorities at BISHCA. Opportunities for additional administrative simplification should be evaluated in the following areas:

- Increasing electronic claim submission requirements
- Developing claims coding for: 1) pending claims with attachments, 2) resubmission of electronic claims, 3) splitting claims, 4) bundling procedures, 5) use of common modifiers, and 6) handling under/over payments.
- Reducing claim turnaround time
- Eliminating paper Explanation of Benefits (EOBs)
- Creating a common provider directory
- Developing a "smart card"
- Developing more provider and member access to data on insurer websites (claims, out-of-pocket costs, price and quality transparency, EOBs)
- Standardizing mental health treatment request forms.

The combination of ACA and Act 48 requires a new phase of strategic planning to simplify administrative processes. The chart below (Table 17) shows the breakout of claim system operating components for which administrative simplification should be considered within any proposed operating system.

Provider Data Management:	**Claims Management:**	**Managed Care/Quality Management:**
• Health plan credentialing • Hospital credentialing • Facility and Professional licensing • Directory services • Provider enrollment • Quality Measures/Physician Profiling • Provider Contracts • Claim history • Payment invoicing • On-line provider access • Precertification; Prior Approval Requests • Submission of additional documentation for precertification or other claim requirements	• Eligibility • Benefits • Coding Conventions • Claim processing (includes claim edits, exceptions, etc.) • Managed care protocols • Denials and adjustments • Paper/electronic processing of facility and professional claims • COB • Payments/EOBs • Web access to claim data • System to system processing • Other Data reporting	• Pre-service review, expedited vs. non-expedited • Prior authorization • Concurrent review, expedited vs. non-expedited • Grievances, expedited vs. non-expedited • Post-service review • Network adequacy • Access and Continuity of Care • Pharmacy benefit management and PBMP interchange • Quality management program structure and P&Ps • Medical management integration with claims system(s) • Data reporting • Hospital and physician quality measures • Chronic care requirements (*Blueprint for Health)* • Disease management programs
Member Data Management:	**Other:**	
• Eligibility • Plan Type/Policy/Benefits/Riders • Out-of-Pocket costs • Claim history/adjustments • Customer service tracking • ID Cards • On-line member access	• Worker's Comp • VHCURES • Subrogation	

Table 17.

It is not yet possible to estimate cost savings associated with these initiatives. As the development of both the Exchange and the universal health system progresses, DVHA will form an advisory workgroup that includes Administration staff, insurers, and providers to create and advance a plan to address administrative simplification in the

near-term context of the Exchange and the longer-term context of a single system. The Exchange Level 1 Implementation grant includes funding to contract for analysis of how to proceed. This analysis will be shared with the Exchange advisory group and this advisory workgroup.

The administrative simplification plan will:

1. Develop methodology for how savings and/or costs should be calculated? (e.g., cost benefit, increased/decreased staff or time, elimination of paperwork, etc.).

Is there a need to separate administrative simplification by state reform vs. federal Exchange requirements?

2. Develop implementation priorities and timeline for administrative simplification tasks.

3. Identify opportunities for efficiencies and barriers to change and develop strategies to resolve them.

Recommendation:

The role of VCAC should be reconsidered due to the broader scope of administrative simplification and the role of the Exchange.

2. Wellness Programs

The Administration envisions that a substantial program of wellness and health promotion will be available to consumers enrolled in health plans through the Exchange, and that such programs will be a precondition of certification as a qualified health plan in Vermont. Background research is needed to determine the parameters and effectiveness of existing wellness programs, including those provided by the Department of Health and programs associated with work site wellness, as well as evidence-based research, to determine which programs are effective at improving health and how such programs can be fully integrated with the Exchange.

DVHA applied for and received federal Exchange funds to hire a contractor to help design a wellness component for the Exchange. Over the next year, the contractor will assist the State to:

- Research existing programs in the State and in other states, including programs designed by insurers and employers
- Review evidence-based research on wellness programs
- Design a wellness program component to be included in the Exchange, including an implementation plan, timeline, and cost
- Develop an integration plan for the Exchange's wellness programs and any programs that exist outside of the Exchange.

IV. Exchange Benefit Packages

A. Covered Services

1. The Federal Essential Health Benefits Package

Background

Section 1302 of the ACA requires that health plans offered through an Exchange and all Medicaid plans cover a minimum set of health care service categories. Specifically, the ACA defines Essential Health Benefits (EHB) to include:

- Ambulatory patient services;
- Emergency services
- Hospitalization
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Prevention and wellness services;
- Chronic disease management; and,
- Pediatric services, including oral and vision care.

The Secretary of Health and Human Services is charged with providing further specificity and consulting with the Department of Labor to establish coverage parameters based on what is included in typical employer plans. The ACA also requires that, in defining the Essential Health Benefits, the Secretary shall:

- Ensure an appropriate balance among categories of services;
- Not make decisions that discriminate on the basis of age, disability, or life expectancy;
- Take into account the diversity of the population; and,
- Ensure that emergency room services cannot require prior authorization

The Secretary charged the Institute of Medicine (IOM) with making recommendations on the criteria and methods for determining and updating the EHB package. The IOM issued its report in October, 2013. The IOM report recommends that HHS adopt the following multi-step approach to determining the initial EHB package:

1. *Identify the typical small group health plan.* Given that ACA initially focuses on expanding affordable coverage to individuals and small employers, the IOM recommends that the starting point for the initial EHB package be a benefit design that is typically available in the small group market.

2. *Modify the typical small employer package to reflect ACA's requirements.* The report recognizes that the typical small employer plan does not include all ten categories of care that ACA requires HHS to include. IOM found that standard benefit packages in the small group market typically do not cover habilitation, mental health and substance use disorder services, some wellness services and chronic disease management, and pediatric oral and vision care.

3. *Adjust the preliminary essential benefits package so that it does not exceed a target cost.* The report recommends that the preliminary essential benefits package be adjusted so that the expected national average premium for a silver-level plan with the EHB package is actuarially equivalent to the average premium that would have been paid by small employers in 2014 for a typical benefit design.

4. *Propose the essential benefits package in regulations.* The report recommends that the Department communicate the EHB in the form of guidance and/or regulation.

5. *Allow states administering their own health exchanges to define their own EHB package.* The report recommends that states administering their own Exchanges be permitted to design their own EHB package as long as they produce a package that is actuarially equivalent to the national package through a process that includes meaningful public input.

Federal Guidance on Essential Health Benefits

On December 15, 2011, the federal Department of Health and Human Services (HHS) released guidance on EHB that signals their intent to offer states more flexibility in defining EHB than was previously believed. The following is an excerpt from that guidance:

HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the Department's intended approach announced today, States would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This approach would give States the flexibility to select a plan that would best meet the needs of their citizens.
States would choose one of the following benchmark health insurance plans:

- *One of the three largest small group plans in the State by enrollment;*
- *One of the three largest State employee health plans by enrollment;*
- *One of the three largest federal employee health plan options by enrollment;*
- *The largest HMO plan offered in the State's commercial market by enrollment.*

To prevent Federal dollars going to State benefit mandates, the health reform law requires States to defray the cost of benefits required by State law in excess of essential health benefits for individuals enrolled in any plan offered through an Exchange. However, as a transition in 2014 and 2015, some of the benchmark options will include health plans in the State's small group market and State employee health benefit plans.

Using this approach, Vermont would likely not have to use state funds to defray the costs of certain state mandates until 2016. The Administration will need to evaluate the options described in the federal guidance and make a recommendation on which option would best serve Vermonters.

2. State Insurance Mandates and the EHB

Prior to the issuance of the federal guidance, the Administration completed a preliminary analysis of how current Vermont coverage mandates compare to the EHB package as described in the ACA. The conclusion is that many of Vermont's mandates are likely to be included in the EHB to be defined by future federal regulations, and some will probably not be included. ***The following chart (Table 18) prepared by Vermont's contractor Bailit Health Purchasing contains the analysis completed for informational purposes only – this information is no longer relevant to defining covered services in 2014 and 2014***:

#	**Health Insurance Mandates Protecting Vermont Consumers – October 2011**[i]	**Federal Mandate (Yes or No)**[ii]	**Essential Health Benefit Category**[iii]
1	**Alcoholism** 8 VSA 4089b - enacted in 1997 Reg. H-2000-03 Bulletin I-116 Bulletin HCA-127 Rule 10/Rule 2009-03 Alcohol or Chemical Dependence. Mandate provides for evaluation and treatment	**Yes**	**Mental Health and Substance Abuse disorder services including behavioral health**
2	**AIDS/HIV Testing/Vaccines** 8 VSA 4724(20) - subdivision added in 1988 - and Bulletin I-92 Statutory language requires insurer to retest upon written request from any individual who was denied coverage or offered reduced coverage due to previous positive test results. It does not mandate any benefit, but includes detailed confidentiality provisions and testing process.	**No**	**n/a**
3	**Alzheimer's Disease** 8 VSA 8085 enacted in 2004, effective 1/1/2005 Not applicable to health insurance only LTC insurance	**No**	**n/a**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
4	**Anesthesia for certain dental procedures** 8 VSA 4100i – enacted in 2010	**No**	**n/a**
5	**Athletic Trainer** 8 VSA 4088g – enacted in 2008 Requires health insurers to reimburse a licensed athletic trainer who acts within the scope of practice if the health insurer would reimburse another health care provider for those services.	**No**	**Rehabilitation; Habilitation and Devices (?)**
6	**Autism** 8 VSA 4088i – enacted in 2010, effective date delayed until 10/1/11 Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. Mandate provides for evaluation and treatment services. Requires coverage for treatment of children from ages 18 months to 6 years.	**No**	**Pediatric Services (?)**
7	**Chemotherapy treatment** 8 VSA 4088c – enacted in 1997 (recodified in 2003) - and Bulleting 1-116 Requires health insurers to provide coverage for medically necessary growth cell stimulating factor injections taken as part of a prescribed regimen	**No**	**Ambulatory Patient Services (?)**
8	**Chiropractic services** 8 VSA 4088a – enacted in 1999 - and Bulletin HCA-105 Requires provision of clinically necessary health care services provided by a chiropractic physician licensed in Vermont for treatment within the scope of practice but limiting adjunctive therapies to physiotherapy modalities and rehabilitative exercise.	**No**	**Rehabilitation?**
9	**Clinical trials for cancer patients** 8 VSA 4088b – enacted in 2001 and amended substantially in 2005 - and Regulation H-2005-03 Provides for payment of routine costs for a patient	**No**	**PPACA requires in other section.**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	participating in a cancer clinical trial, including when one is not available in VT or NH.		
10	**Colorectal cancer screening** 8 VSA 4100g – enacted in 2009 Colon Cancer (also commonly called colorectal cancer) refers to any cancer in the colon, rectum, appendix and anus. Mandate provides for evaluation and limits cost-sharing.	**No**	**n/a**
11	**Congenital Bleeding Disorders** Regulation 80-1 Inherited bleeding condition typically associated with low levels of absence of a blood protein essential for clotting such as hemophilia and Von Willebrands. Mandate provides for evaluation and treatment	**No**	**n/a**
12	**Contraceptive mandate:** 8 VSA 4099c – enacted in 1999 - and Bulletin HCA-105 Birth Control pharmaceuticals and devices. Mandate provides coverage for a range of FDA-approved prescription contraceptive drugs and devices.	**No**	**n/a**
13	**Craniofacial disorders** 8 VSA 4089g – enacted in 1997 Requires health insurers to provide coverage for diagnosis and medically necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face neck or head and is the result of accident, trauma, congenital defect, developmental delay or pathology.	**No**	**Hospitalization (?) or Ambulatory patient Services (?)**
14	**Diabetic Self-Management and Supplies** 8 VSA 4089c – enacted in 1997, Bulletins I-116 & HCA-108 Mandate provides payment for evaluation,	**No**	**Preventative, wellness and Chronic disease management**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	education & treatment for self-management and for evaluation and supplies of durable medical equipment and certain medicines for diabetics		**(?)**
15	**Drug Treatment** 8 VSA 4089b – mental health parity statute enacted in 1997 Reg H-2000-03 Bulletin I-116 Bulletin H-127 Rule 10 and 2009-03 Mandate provides for evaluation, education and treatment of those dependent on both legal and illegal drugs	**Yes**	**Mental Health and Substance Abuse disorder services including behavioral health**
16	**Emergency Treatment** Rule 10 section 10.203(E) Mandate provides for appropriate medical care in emergency situations based upon the "prudent layperson" standard.	Yes	**Emergency Services**
17	**Home Health Care** 8 VSA 4096 – enacted in 1975 An individual or group health insurance expense policy and an individual or group service contract issued by a nonprofit hospital corporation which provides hospital or medical coverage shall provide as an option coverage for home health care	No	**Rehabilitation?**
18	**Long Term Care** 8 VSA 8081 et seq and Reg. H-2009-01 Not applicable to health insurance, just to long term care insurance	No	**n/a**
19	**Mammogram** 8 VSA 4100a – enacted in 1991, amended in 2007 An x-ray of the breast to detect breast changes in women. Mandate provides for the x-ray and evaluation and limits cost-sharing.	No	**Preventative, wellness and Chronic disease management ?**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
20	**Maternity** 8 V.S.A. § 4096 – Home health requires coverage for maternity and childbirth – enacted in 1975 8 V.S.A. § 4099d – plans covering maternity care must also cover midwifery and home births – enacted in 2011 Bulletin 54, 1-95, 96, and I-114 and Regulation 89-1 Mandate provides for prenatal & postpartum doctor evaluation and care during pregnancy.	Yes	**Maternity and newborn care**
21	**Maternity Stay** Bulletin 54 Bulletins 1-95 and 96 Bulletin I-114 Regulation 89-1 Those insurers that provide coverage for maternity must allow a patient to remain in the hospital for a minimum specified amount of time according to federal law (usually one to two days for vaginal delivery and three to four days for cesarean delivery) following the delivery of a baby	Yes	**Maternity and newborn care**
22	**Mental Health – general** – mental health parity statute enacted in 1997 8 VSA 4089b Rule 10 Bulletin I-116 Bulletin HCA-127 Although most states define mental health as a state of emotional and psychological well-being, they often differ on what they include in evaluation and treatment. The mandate provides for the payment of mental health evaluation and treatment.	Yes	**Mental Health and Substance Abuse disorder services including behavioral health**
23	**Mental Health Parity** – mental health parity statute enacted in 1997	Yes	**Mental Health and Substance**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	8 VSA 4089b Rule 10 Bulletin I-116 Bulletin HCA-127 The federal parity requirements apply only to plans that include mental health benefits in their benefit package. A health plan may not place annual or lifetime dollar limits on mental health benefits that are lower or less generous than annual or lifetime dollar limits for medical and surgical benefits offered under that plan. Due to federal law, substance abuse benefits are now included along with mental health parity benefits.		**Abuse disorder services including behavioral health**
24	**Midwifery services and home births** 8 VSA 4099d – enacted in 2011 Requires a plan that covers maternity care also to cover services provided by licensed midwives and certified nurse midwives in a hospital or at home.	No	**Maternity and newborn care (?)**
25	**Naturopathic physicians** 8 VSA 4088d – enacted in 2007 The mandate requires health insurers to cover medically necessary health care services provided by a naturopathic physician if the services are otherwise covered under the plan.	**No**	**Prevention and Wellness (?)**
26	**Newborns** 8 VSA 4092 – enacted in 1975 A newborn is included under a parent's individual insurance policy for 31 days, as long as the policy already provides coverage for dependents.	**Yes**	**Maternity and newborn care**
27	**Off label drug use (cancer only)** 8 VSA 4100e – enacted in 2005 Coverage or offering of drugs for treating a	**No**	**Prescription drugs (?)**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	particular disease even though they are not approved for a specific purpose by the FDA. Mandate requires health insurance plans that cover prescription drugs to cover off-label use in cancer treatment.		
28	**Oral cancer medications** 8 V.S.A. § 4100h – enacted in 2009 Requires a health insurer to provide coverage for prescribed, orally administered anticancer medications if the insurer provides coverage for cancer chemotherapy treatment	**No**	**Ambulatory patient services (?) Prescription drugs (?)**
29	**Pediatric Immunizations** 8 V.S.A. § 4100d – enacted in 1994 Prohibits insurers from reducing child vaccine benefits below May 1, 1993 coverage	**No**	**Pediatric services(?) Preventative, wellness and Chronic disease management ?**
30	**PKU/Formula/Metabolic Disease Foods** 8 VSA 4089e – enacted in 1998 - and Bulletin I-122 An insurer shall provide coverage for medical foods prescribed for medically necessary treatment for an inherited metabolic disease such as phenylketonuria (PKU)	**No**	**N/A**
31	**Prescription Drugs** 8 VSA 4089i and 8 V.S.A. 4089j – both enacted in 2004 4089j requires health insurers to provide coverage for pharmaceuticals at the same quantity and co-pay for retail and mail order pharmacies. 4089i requires coverage for prescription drugs purchased in Canada, and used in Canada or reimported	**No**	**Prescription drugs**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	legally or purchased through the I-SaveRx program on the same benefit terms and conditions as prescription drugs purchased in this country		
32	**Prostate Cancer Screening** 8 VSA 4100f – enacted in 2007 Prostate cancer is the growth of malignant prostate glandular cells in the prostate gland. Mandate provides for the evaluation.	**No**	**Prevention and Wellness (?)**
33	**Prosthetic parity** 8 VSA 4088f – enacted in 2008 Prosthetics deals with the production and application of artificial body parts. Mandate provides for evaluation, treatment and supplies.	**No**	**Rehabilitation; Habilitation and Devices (?)**
34	**TMJ Disorders** Bulletin I-63 TMJ, temporomandibular joint disorder, is caused by the displacement of the cartilage where the lower jaw connects to the skull. Mandate provides for the evaluation and treatment.	**No**	**n/a**
35	**Tobacco Cessation programs** 8 VSA 4100j – enacted in 2010 A health insurance plan shall provide coverage of at least one three-month supply per year of tobacco cessation medication, including over-the-counter medication, if prescribed by a licensed health care practitioner for an individual insured under the plan. A health insurance plan may require the individual to pay the plan's applicable prescription drug co-payment for the tobacco cessation medication.	**No**	**Prevention and Wellness (?)**

Table 18.

B. Exchange Plan Design

1. Exchange for Individuals & Families

As discussed above, the Exchange may be used to unify and simplify health plans. Under Act 48, the Exchange is responsible for providing eligible individuals and small employers with Qualified Health Plans (QHPs). To do this, the Exchange must conduct a number of activities that are described below. These activities can be conducted by DVHA staff, or the Exchange may enter into intergovernmental agreements with other State agencies, or contract with qualified entities to perform the services.

- *Determining eligibility and plan enrollment.* Vermont intends to use a single, streamlined process for determining eligibility for premium tax credits under the Exchange, as well as eligibility for Medicaid, Dr. Dynasaur, and other public programs. People will be able to apply online, through the mail, or in person.

- *Selecting health benefit plans, including multistate plans.* The Exchange must develop a process for certification, decertification, and recertification of QHPs, assign quality and wellness ratings to plans offered through the Exchange, and determine the level of coverage being offered (silver, gold, or platinum). DVHA will be contracting with a vendor under its federal Exchange grant to assist in the development of the plan certification process, including the certification criteria and QHP plan designs.

- *Health plans must obtain premium approval through a rate review process*, including justification for any premium increases and must prominently post premium information on their websites. To offer in the Exchange, insurers must offer at least one silver and one gold level plan. At its option, an insurer may offer a plan at the platinum level. Insurers must charge the same premiums for the same coverage in and out of the Exchange and whether or not offered directly or by an insurance agent.

- *Outreach and Education.* The Exchange must create and maintain consumer assistance tools, including a website that contains standardized comparative information on qualified health plans, a toll-free hotline, and interactive online communication tools that comply with the Americans with Disabilities Act. The Exchange must use standardized forms and formats for presenting health benefit options.

  The Exchange must establish a navigator program to assist individuals and employers in enrolling in coverage under the Exchange. The Exchange is charged with selecting qualified individuals and entities to serve as navigators and award grants or contracts to such organizations to provide navigator services. DVHA will be contracting with a vendor to help design the navigator program.

- *Determining exemption from insurance mandate*. The Exchange must determine whether an individual is exempt from mandate requirements based on the lack of an affordable plan through the Exchange or employer.

- *Financial Integrity.* The Exchange must keep accurate accounting of all activities, receipts, and expenditures and submit reports annually as required by federal law. The Exchange is required to publish and place on its website the average costs of licensing, regulatory fees, and other payments required by Exchange; and its administrative costs; including monies lost to waste, fraud and abuse.

- *Appeals and Grievances.* The Exchange must provide easy access to grievance and appeals processes and refer consumers to the ombudsman for assistance with grievances and appeals.

- *Evaluation.* The Exchange must conduct satisfaction surveys with consumers and use other mechanisms to evaluate plan performance. Results of the consumer satisfaction surveys must be published on the Exchange website.

During 2012 DVHA will be using federal Exchange planning grant funds to contract with vendors with the expertise to help design all of the functions described above. Vermont will leverage its current infrastructure wherever possible to ensure that development of the Exchange is cost-effective while providing the best possible service to individuals and small businesses. For example, the State already collects premiums from Catamount Health enrollees and sends premiums to the carriers, so it can build on this process for the Exchange. In addition, DVHA operates a call center, and BISHCA reviews rate filings, so both of these processes could be modified and enhanced to meet Exchange requirements.

2. Exchange for Employers: the Small Business Health Options Program (SHOP)

Under Vermont's proposed Exchange Design, the State will operate one Exchange that serves both individuals and small employers. In determining how to structure its Exchange for small employers, the State must first determine goals for the small business Exchange, including:

- Administrative simplification of the health care system;
- Maximization of the purchase of insurance through the Exchange by reducing the burden on the employer while enabling employee choice; and
- Usage of existing infrastructure and functions for efficiencies, including the creation of similar processes for the individual and small business Exchange as appropriate.

Two key decisions for the Exchange design are 1) how much choice to allow small businesses and/or their employees in the selection of health plans through the Exchange, and 2) how plan enrollment and premium payment will be facilitated. Under the federal rules, employers will be able to initially enroll in coverage through the Exchange at any time of the year; renewals will occur on an annual basis.

There is a continuum of plan selection options for the State to consider in the development of its Exchange. The options range from employers maintaining control over the plan selection for their employees to allowing employees the maximum choice of plan. Each option presents a number of benefits and challenges that must be considered before the State selects a final design.

The Administration has identified five options detailed in Table 19 below. The options vary based on whether the employer selects the insurer, the tier (i.e., silver, gold, or platinum) and/or the product within the tier.

Table 19: Plan Selection Options

Option	Description
A	Employer selects both tier and product
B	Employer selects tier; employee selects product within the tier
C	Employer selects insurer; employee selects tier and product
D	Employer selects base tier; employee selects product at, above or below tier
E	Employer provides defined contribution for individual to purchase directly through the Exchange.

DVHA will be contracting with a vendor to help design the small business function for the Exchange. The Administration has already begun obtaining feedback from stakeholders on these options, and will continue to test the options with employers, employees, insurers, and other stakeholders before a final decision is made.

3. Common Benefit Plan Designs

The ACA defines four categories of plans plus a separate catastrophic plan. The four comprehensive plans each provide Essential Health Benefits and maintain Health Savings Account out-of-pocket limits. Out-of-pocket limits are reduced for consumers with incomes below 400% FPL. The plans must have the following actuarial values:

- **Bronze plan:** 60%
- **Silver plan:** 70%
- **Gold plan:** 80%
- **Platinum plan:** 90%

"Actuarial value" is the percent of total claims costs that a plan will pay on average. So a gold plan, which as an actuarial value of 80%, would on average pay 80% of an individual's health care costs. The individual would therefore pay 20% of costs out of pocket (up to the out-of-pocket limit).

Exchanges may offer catastrophic plans to individuals up to age 30 or to those who are exempt from the mandate to purchase coverage.

Act 48 provides for platinum, gold, and silver plans on its Exchange. Issuers wishing to offer plans on the Exchange must offer at least one silver and one gold plan. The state is seeking additional guidance from CMS on whether it is allowable to set the cost-sharing standard at a level above bronze. If CMS indicates that this is not allowed, the Exchange will include bronze plans.

4. Future Analysis and Recommendations

A recent conference participant made the remark that "you can drive a truck through actuarial value," meaning that there are almost limitless variations in cost-sharing that would yield the same actuarial value. For example, one plan might offer a low deductible and high co-pays, while another plan might offer a high deductible and low co-pays, yet both would receive the same actuarial value. Research in other states with Exchanges already in operation, particularly Massachusetts, has shown that offering too many choices of plans to consumers is confusing and can result in some consumers failing to follow through on the enrollment process.

The Administration believes that Vermont should develop standard benefit designs in the silver, gold, and platinum categories. So, for example, multiple insurers could offer a silver plan on the Exchange, but the plan would have to follow one or more standard silver plan designs. In this way, consumers will have a less confusing array of plans to compare when deciding which plan works best for that consumer.

DVHA will be contracting with a vendor in early 2012 to help develop standard benefit designs for the three categories of plans that will be offered on Vermont's Exchange. Public input will be sought prior to making a final recommendation to the Green Mountain Care Board on plan designs.

C. Supplemental Insurance Coverage

Act 48 explicitly requests comment on "the impact of the availability of supplement insurance plans on offerings in the small and individual group markets."
A simplified definition of supplemental health insurance plans are forms of insurance that bridge the gap between a "core" comprehensive health care benefit package (Medicare Parts A and B or the "essential benefits" that must be offered in the Exchange) and the outside limits of coverage that people are willing to pay for with their own funds or funds identified to them (e.g., a retirement benefit). These expanded coverage categories could include types of care or providers not ordinarily covered or a higher percentage of the cost of care paid by an insurer rather than out of the patient's pocket.

Under the federal Affordable Care Act and Vermont law, there is no prohibition of the sale of supplemental coverage. Supplemental coverage, sold separately without employer contribution, would not impact the number of Vermonters purchasing comprehensive coverage unless it became a means of reducing the scope and cost of that coverage. This is an unlikely option in view of Vermont's tradition of mandating comprehensive care with a generous benefit package but perhaps worth consideration among possible steps to reduce the cost of basic coverage. There are, however, some coverage benefits that are not included in traditional comprehensive care but nevertheless are obtained by many Vermonters and make an acknowledged contribution to a healthy life. Dental care—explicitly mentioned in federal law as allowable in the exchange--vision care and perhaps others are possible candidates for inclusion in Vermont's essential benefit package.

Possible considerations when determining the role of supplemental coverage:
Pros

- No Vermonter would be prevented from purchasing as much coverage as he or she wants
- The additional cost of supplemental coverage is borne by the purchaser but not by the community
- The ready availability of supplemental coverage in Vermont might make feasible a less costly array of essential benefits required in all basic coverage
- Pressure to create new state health insurance mandates would be reduced

Cons

- Demand for less essential types of care would likely increase, raising the overall cost of health care in Vermont
- Vermonters with supplemental coverage would arguably have access to "better" care than those without
- Supplemental coverage might encourage utilization of unnecessary care

Supplemental coverage cannot be defined until the covered services and cost-sharing is defined, so additional work will be required on this issue.

V. Individual Mandate

Introduction
Beginning in January 2014, the Affordable Care Act (ACA) will require individuals to maintain minimum essential health insurance coverage each month or pay a penalty. Act 48 states that no later than January 15, 2012, the commissioner of the Department of Vermont Health Access shall recommend to the house committee on health care and the senate committees on finance and on health and welfare any additional enforcement mechanisms necessary to ensure that most, if not all, Vermonters will obtain sufficient health benefit coverage.

This report includes an outline of the ACA requirement to maintain minimum essential health insurance coverage and explains the penalty for failing to meet the requirement. The report compares the ACA penalty with the Massachusetts penalty for failing to

comply with the individual mandate and examines the role of the later in expanding health care coverage in the Commonwealth. In addition, the report explores the efficacy of drivers' license suspension as a potential tool for enforcing the minimum essential coverage requirement, should it be maintained in the ACA. The general assembly is advised not to pursue additional legislation relating to the requirement to maintain minimum essential coverage until the constitutionality of the mandate has been decided in the United States Supreme Court, likely in the summer of 2012.[iv]

Requirement to Maintain Minimum Essential Coverage
Chapter 48 of the Affordable Care Act, Maintenance of Minimum Essential Coverage Sec. 1501\5000A IRC requires individuals to maintain minimum essential health insurance coverage each month or pay a penalty. An individual is exempt if his or her required contribution (determined on an annual basis) for coverage for the month exceeds 9.5% of his or her household income for the taxable year or if his or her income is below the tax-filing threshold. In addition, exemptions from the penalty are available for those without coverage for less than three months, those with religious objections, American Indians, undocumented immigrants, incarcerated individuals, and those who document other financial hardship.[vvi]

Penalty for Failure to Maintain Minimum Essential Coverage
The annual penalty will be the *greater of* a flat dollar amount per individual *or* a percentage of the individual's taxable income. For any dependent under the age 18, the penalty is one half of the individual amount.

The flat dollar amount per individual is $95 in 2014, $325 in 2015 and $695 in 2016. After 2016, the flat dollar amount is indexed to inflation. The flat dollar penalty is capped at 300% of the flat dollar amount.

The percentage of taxable income is an amount equal to a percentage of a household's income that is in excess of the tax-filing threshold (phased in at 1% in 2014; 2% in 2015; 2.5% in 2016). For example: if an individual has a household income of $50,000, the percentage would be 1% of the difference between $50,000 and the tax threshold (which is $9,350 for an individual in 2010). Supposing the tax threshold is $10,000 in 2014, this individual would be subject to a percentage penalty of $400. Because this percentage penalty is greater than the flat dollar penalty for 2014 (which is $95), he would pay the percentage penalty.

Generally, the annual penalty is capped at an amount equal to the national average premium for qualified health plans that have a bronze level of coverage available through the state Exchange.[vii]

Minimum Essential Coverage Requirement in Massachusetts
The Massachusetts Health Reform Law (Chapter 58) TIR 09-25: Individual Mandate Penalties for Tax Year 2010[viii] specifies that a resident who has access to affordable coverage but who does not obtain the coverage, and to whom an exception does not apply, is subject to penalties. The Act requires most adults age 18 and over with access to

affordable health insurance to obtain it.

Individuals must be enrolled in health insurance policies that meet minimum creditable coverage standards defined in regulations adopted by the Commonwealth Health Insurance Connector Authority (the Connector). The Massachusetts Health Connector has a progressive affordability schedule ranging from 2.1 to 9.6% of household income, depending on income bracket. After a ninety-day grace period, people are penalized for each month they are not insured in the previous tax year.[ix]

Penalties for individuals with incomes from 150.1 to 300% of the Federal Poverty Level are half of the lowest-priced Commonwealth Care enrollee premium that could be charged to an individual at the corresponding income level, based on the Connector's Commonwealth Care enrollee premiums as of January 1, 2010.[x]

Penalties for individuals with incomes greater than 300% of the Federal Poverty Level will be: *ages 18-26:* half of the lowest priced individual Commonwealth Choice Young Adult Plan premium; and *ages 27 and above:* half of the lowest priced individual Commonwealth Choice Bronze premium based on the Connector's prices for these plans as of January 1, 2010. Penalties for married couples who do not comply with the individual mandate rules (with or without children) will equal the sum of individual penalties for each spouse.

Individuals with incomes up to 150% FPL are not subject to any penalty for non-compliance, as those at this income level are not required to pay an enrollee premium for Commonwealth Care health insurance.[xi]

Despite famously employing the individual mandate as a tool for promoting universal coverage in the Commonwealth, experts argue that by itself, the individual mandate does not explain the high rate of insured Massachusetts residents. Since the individual mandate is not enforced against adults under 150% FPL, there is a large number of individuals in Massachusetts who have gained coverage but have not been mandated to do so. Policy makers, stakeholders, and advocates cite an integrated system with a single application form and an easy eligibility determination process as the key reasons that so many Massachusetts residents have gained health insurance coverage since reform was enacted in 2006. [xii] In addition, experts agree that the broad public awareness effort was central to expanding health care coverage in Massachusetts. Public advertising campaigns encouraging uninsured consumers to enroll coupled with on-the-ground outreach efforts by nonprofit and hospital and community health center groups were key to expanding coverage.[xiii]

License Suspension as an Additional Penalty

The rates of detection, prosecution, and conviction of drivers who operate with suspended licenses have typically been very low. Drivers who have their licenses suspended or revoked for non-traffic-related offenses, such as failure to pay child support, do not pose a significant risk on highways; evidence shows these drivers to have a traffic risk no greater than drivers who do not have their licenses suspended. Non-traffic offense license suspensions have been said to clog the system and weaken actual traffic safety efforts.

The United States Government Accountability Office reports that license suspensions make it difficult for some low-income individuals to maintain or find work, which makes it an even greater challenge for these same individuals to pay fines or meet other financial obligations, such as purchasing health care.

In Vermont, 17,125 licenses were suspended in 2010 and 7,365 subsequent violations occurred for operating a vehicle with a suspended license. It is important to note that different individuals did not necessarily commit the 7,365 subsequent violations; one individual may have had multiple subsequent violations.

Recommendations:
Legislative action is premature until the U.S. Supreme Court acts on the pending case challenging the federal individual mandate.

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[i] Information from the VT Department of Banking, Insurance, Securities and Health Care Administration

[ii] Information from the Council for Affordable Health Insurance *Health Insurance Mandates in the States 2009* including the following federal legal references- Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, 110 Stat. 2874, 2944; the Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, Title VI, 110 Stat. 2874, 2935; and the Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, Title IX, 112 Stat. 2681, 2681-436.

[iii] Information from the National Health Council *Essential Health Benefits White Paper* September 2010; because final definition of Essential Health Benefit has not been released, this categorization only provides a potential match. Final regulations defining Essential Health Benefits are not expected to be released from the federal government until 2012.

[iv] Wendy K. Mariner, J.D., M.P.H., Jack M. Balkin, J.D., Ph.D., and Ilya Somin, J.D. *The Constitutionality of the Individual Mandate* N Engl J Med 2011; 365:e36 October 27, 2011

[v] Kaiser Family Foundation. Focus on Reform. Summary of New Health Reform Law. Available at: http://www.kff.org/healthreform/upload/8061.pdf.

[vi] Compilation of Patient Protection and Affordable Care Act and Health-Related Portions of the Health Care and Education Reconciliation Act of 2010. Available at: http://docs.house.gov/energycommerce/ppacacon.pdf

[vii] ibid.

[viii] Massachusetts Department of Revenue. TIR 09-25: Individual Mandate Penalties for Tax Year 2010. Available at: http://www.mass.gov/?pageID=dorterminal&L=7&L0=Home&L1=Businesses&L2=Help+%26+Resources&L3=Legal+Library&L4=Technical+Information+Releases&L5=TIRs++By+Year(s)&L6=2009+Releases&sid=Ador&b=terminalcontent&f=dor_rul_reg_tir_tir_09_25&csid=Ador

[ix] Massachusetts Health Connector. Find Insurance: Frequently Asked Questions. Available at: https://www.mahealthconnector.org/portal/site/connector/menuitem.afc6a36a62ec1a50dbef6f47d7468a0c/?fiShown=default

[x] ibid.

[xi] ibid.

[xii] Dorn, Stan; Hill, Ian and Sara Hogan. The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage. State Health Access Reform Evaluation. November, 2009.

[xiii] McDonough, John E., Rosman, Brian, Butt, Mehreen, Tucker, Lindsey, and Lisa Kaplan Howe. Massachusetts Health Reform Implementation: Major Progress and Future Challenges. *Health Affairs-Web Exclusive.* W285-w297. June, 2008.